



Older Hispanics' Explanatory Model of Depression



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ABSTRACT

Cultural variations in the perception of depression make it difficult to recognize the disorder resulting in older Hispanics not being diagnosed and not receiving appropriate treatment. This study used a mixed-method design to explore older Hispanics' explanatory model of depression. Depression was recognized as the result of life stressors and personal weaknesses. Terms used for depressed people included "crazy, worry, bored, and nerves." These culturally coded terms may confound diagnosis among many Hispanics who find depression a shameful condition. Findings can be used to inform the adaptation of culturally relevant approaches to better serve the Hispanic community in this country.

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Older Hispanics face disparities in the recognition and treatment of depression (Lewis-Fernandez, Das, Alfonso, Weissman, & Olsson, 2005). One reason may be that the conceptualization of depression as a social problem or emotional reaction among Hispanics differs from the biomedical model of depression as a condition requiring mental health treatment (Vega et al., 2007). Steffens, Fisher, Langa, Potter, and Plassman (2009) reported that the lifetime prevalence of depression among older Americans was 11.9%. An epidemiological study on Hispanics' mental health, however, found that the lifetime prevalence rate for major depression was 20.1% for Puerto Ricans, 18.6% for Cubans, 14.7% for Mexicans, and 13.9% for other Hispanics (Alegria, Canino, Stinson, & Grant, 2006).

Researchers measuring depression among ethnic minorities and White non-Hispanics in different parts of the U.S. have suggested that older Hispanics report the highest levels of depression (Jang, Chiriboga, Kim, & Phillips, 2008; Rodriguez-Galan & Falcon, 2009; Russell & Taylor, 2009). In fact, researchers who used the Center for Epidemiologic Study Depression Scale (CES-D) (Radloff, 1977) to measure depressive symptoms among minority groups and European-Americans in Massachusetts reported that 26% of African-Americans, 32% of Cubans, and 30% of non-Cuban Hispanics scored above the cut off for depression, whereas the proportion of European-Americans was only 15% (Jang et al., 2008).

Depression has been associated with delays in access to medical care resulting in late diagnosis and treatment of medical illnesses among older Hispanics (Rodriguez-Galan & Falcon, 2009). Higher levels of depressive symptoms have been associated with cognitive

decline in older Hispanics (Rotkiewicz et al., 2006). Most seriously, depression has been associated with high rates of suicide attempts among Puerto Ricans ages 20 to 74 (Oquendo, Lizardi, Greenwald, Weissman, & Mann, 2004).

Despite the increasing number of studies reporting depressive symptoms among older Hispanics, little is known about Hispanics' explanations of depression. Most of the research on older Hispanics' depression has been quantitative. Cultural perspectives of depression are often missing. The differences between low-acclimated and high-acclimated older Hispanics' concept of depression have simply not been examined. This gap is of concern to practitioners because culture impacts the idioms used to report the symptoms, help-seeking behaviors, communication between patients and providers, protective psychological factors, and outcomes as serious as suicide (Kleinman, 2004).

Cultural variations in the way Hispanics view depression and report symptoms may make difficult to recognize the disorder. This means older Hispanic patients with depression may not be diagnosed and may not receive appropriate treatment (Cabassa, Lester, & Zayas, 2007). Also, differences in the explanatory model of depression from the biomedical model may lead to underutilization of mental health care services and treatment (Karasz, 2004). To address the gaps in research related to the cultural explanation and perceptions of depression among older Hispanics, the present study explored older Hispanics' concept of depression, their coping mechanisms and help seeking behaviors, and culture-specific factors that may help in the recognition and treatment of depression. Two questions guided this research:

What are older Hispanics' explanatory model of depression and their explanations of its causes, effects, and treatment preferences?
Is there a difference in the explanatory models of depression between high and low-acclimated, depressed and non-depressed Hispanics?

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METHOD

This study used a mixed-method design that combined qualitative and quantitative methods (Creswell, 2009). The core component of this study was an interview adapted from Kleinman's (1980) Explanatory Models ethnographic approach with an added vignette variation. Kleinman's Explanatory Models is a mini-ethnography that consists of an interview technique to understand how illness is perceived, interpreted, and explained from the patient's own point of view (Kleinman & Benson, 2006). The concept of explanatory models refers to the idea that people from a given culture often have their own concepts and perceptions of illnesses, which may differ from those held by the clinicians. Explanatory models of patients and families provide insight into their mental process regarding the illness and potential treatments (Kleinman, 1980). How illness is perceived and how treatment is experienced may all form part of the total picture that health care providers need to take into account. Kleinman's Explanatory Models guided the collection of qualitative data.

A quantitative methodological strategy was also used with the inclusion of two instruments. The first scale was the Center for Epidemiologic Studies Depression Scale (CES-D) developed by Radloff (1977). The second scale was the Cross Cultural Measure of Acculturation (CCMA) developed by Tappen, Rosselli, & Williams in 2002. The information obtained from these measurements was used to establish categories, depressed and non-depressed and high and low-acculturation.

Participants

The sample was purposively selected for maximum variation among participants. A total of 50 participants were included in this study. The criteria for selection included: a.) 55 years old and older, b.) self-identified Hispanics who speak Spanish and/or English, and c.) residence in South Florida (Miami-Dade, Broward, and Palm Beach counties). Hispanics younger than 55 years old residing outside of South Florida and ethnic groups other than Hispanics were excluded. IRB approval was obtained from Florida Atlantic University for this study. All information and informed consent material was in the preferred language (English or Spanish) of the participants.

Procedures

Prior to the study, a pilot study was conducted among twelve individuals (6 low-acculturated individuals and 6 high-acculturated individuals) who exhibited characteristics similar to those who comprised the study population. The purpose of the pilot study was to field test the method, techniques, case vignette, and interview guide for applicability and adequacy in exploring concepts and perceptions of depression among older Hispanics. Participants were interviewed using a draft copy of the vignette, interview questions, and questionnaires using the same data collection procedures described in the study. They were asked to read aloud the information exactly as written and to give their feedback, thoughts, and overall impressions on the vignette, questions, and techniques. A research method known as "think aloud" (Charters, 2003) was used to elicit information from participants regarding their thoughts as they read the vignette and interview questions. Think aloud research methods have been shown to have "a sound theoretical basis and provide a valid source of data about participant thinking" (p. 1).

The pilot study exposed aspects of the project that needed revisions (Polit & Hungler, 2008). Participants' comments helped facilitate the understanding, use of wording, interpretation, presentation of the interview questions, and led to their revision. Therefore, interview questions were revised to facilitate communication and interaction between participants and the researcher. No changes

needed to be made to the case vignette based on the participants' feedback.

Data Collection

Participants for this study were recruited through a Spanish-speaking church, an agency for older Hispanics, and network sampling by word of mouth. Mutually-convenient appointments and locations for interviews were set up with individuals who agreed to participate. After a period of rapport building, participants were asked to answer some demographic questions. Next, the case vignette related to depression was presented to elicit participants' explanatory models of depression. After the interviews, participants were also asked to complete two questionnaires. The CES-D measured their depression level, and the CCMA measured their acculturation level. The results were used to establish categories to compare participants' descriptions of the phenomenon.

Measures

Demographic Questionnaire

Participants were asked to complete a brief demographic survey which did not ask for any identifying information. Demographic data included information regarding gender, age, education, socioeconomic status, marital status, history of medical conditions, country of origin, and years lived in the U.S.

Interview Guide

The interview guide used to answer the research questions in this study was based on Kleinman's Exploratory Models ethnographic approach with a vignette variation. The interview guide consisted of a vignette portraying an individual with depressive symptoms adapted from the vignette used by Sulaiman, Bhugra, and de Silva (2001) and based on the DSM-IV-TR depression categories without using technical language (American Psychiatric Association, 2000). The vignette did not indicate age, gender, or any other descriptor associated with the individual, except for depressive symptoms and behavior. The second part of the interview guide incorporated open-ended questions, adapted from the revised cultural formulation of Kleinman's Explanatory Models Approach interview questions (2006). The aim was to produce a concise, vivid, and easy to understand picture of the clinical condition. To answer the interview guide questions, participants were asked to assume the role of the person described in the vignette.

Case Vignette

A person has been unhappy for the past 5 months, has lost interest in doing normal day-to-day activities, and feels as if life isn't worth living anymore. Furthermore, this person has difficulty sleeping and has not been eating well. Also, this individual complains of having troubles such as headaches, stomachaches, general weakness, and lack of energy. This person does not want to get out of the house anymore. This individual has difficulty concentrating, making decisions, and lacks the desire to do anything. Friends and relatives have commented on this person's 20 lbs. weight loss and frequent irritability and tearful outbursts.

The following questions were asked after reading the vignette:

1. What do you call the problem expressed in the story?
2. What do you believe is the cause of this problem?
3. What course do you expect it to take?
4. How serious is it?
5. What do you think this problem does inside your body?
6. How does it affect your body and your mind?
7. What do you most fear about this condition?
8. What do you most fear about the treatment?

9. Is there anything that can be done about it?
10. What would you do?
11. Would you seek help from mental health professionals?
12. Why or why not?

Acculturation Scale

The CCMA was used to measure the degree of acculturation to mainstream America culture and to the individual's heritage culture. It is has two parts. Part one of the scale measures orientation to an individual's own culture of origin (19 items) and part two measures orientation to mainstream American culture (19 items). It contains a total of 38 items (Tappen, 2011). The possible total scores range from one to five on each item. The scale scores from both cultural domains can be used to determine the degree of acculturation (Tappen, 2011). The use of the CCMA subscales to categorize participants in low-acculturated (heritage culture) and high-acculturated (mainstream American culture) in the present research study was based on early CCMA work. Recent work on the CCMA has suggested that there are two subscales within each scale (R. Tappen, personal communication, June, 17, 2013). The CCMA scale has been reported to have high reliability and validity among more than one ethnic group including African Americans, Afro-Caribbeans, European Americans, and Hispanic Americans.

Depression Scale

The CES-D Scale was used to screen for depressive symptoms. The CES-D scale is a 20-item self-report inventory of depressive symptoms. The possible range of scores is from 0 to 60. A cutoff of 16 or greater was used to define depressive symptoms in this study since 16 has been established to differentiate between clinical and nonclinical descriptions of depression (Radloff, 1977). The CES-D scale has internal consistency supported by reported Cronbach's alpha scores of .85 and .90 (Posner, Stewart, Marin, & Perez-Stable, 2001). It has been widely used in older populations and with older Latinos (Posner et al., 2001). The 11 participants from this study who scored 16 or above were under the care of a primary care physician for depression.

Data Analysis

The text was analyzed with the following clear and overriding research question in mind: "What are older Hispanics' explanatory model of depression and their explanations of its causes, effects, and treatment preferences?" Analysis of the qualitative data was conducted through thematic analysis by coding, identifying patterns, categories, and themes and reconstructing them in "a meaningful and comprehensible way" (Wolf, 2007, p. 312). Secondary research question was: "Is there a difference in the explanatory models of depression between high and low acculturated, depressed and nondepressed Hispanics?" For these questions, participants were categorized into subsamples (using scale scores), and qualitative findings were compared.

In the first step of the analysis, data from interviews were transcribed and translated by the researcher and checked for accuracy by two different bilingual and biliterate Hispanic individuals. The second step involved data organization, management, and preparation of the transcripts for coding. The result was an organization of the data in tables from the specific (transcript data or descriptive findings) to the more abstract including patterns (recurrent concepts, key words), narrative expressions (significant statements, cultural idioms), and interpretations from interviews for each category of participant (low-acculturated/depressed, low-acculturated/nondepressed, high-acculturated/depressed, and high-acculturated/non-depressed). The third step involved discovering themes through an inductive process. Themes were created by grouping participants' explanations of depression in categories to reflect participants' responses to Kleinman's Exploratory Models Approach interview questions. Next, comparison between the groups (depressed with non-

depressed, and high-acculturated with low-acculturated) and their descriptions and explanations of depression was conducted. This process of data analysis helped answer the research question, "Is there a difference in the explanatory models of depression between high and low acculturated, depressed and non-depressed Hispanics?" by allowing the researcher to describe, compare, and relate findings from the qualitative interview with results of the questionnaires as suggested by Bazeley (2009). Similarities and differences between categories in relation to themes were described. Also, themes that occurred more or less frequently for different groups were identified. Furthermore, relations were established between themes to others that were found the literature.

To analyze the quantitative data, scores from the quantitative instruments were used to create dichotomous groups, high and low acculturated and depressed and non-depressed. Participants were placed in high and low acculturation groups based on the results of the CCMA. The score of 57 was used as a cutoff score to indicate low and high levels of acculturation. A cutoff score of 16 on the CES-D was used to determine whether a participant will be categorized as clinically depressed (Radloff, 1977). Participants who scored 16 or above were categorized as having depressive symptoms. Furthermore, demographic data including: gender, age, education, socioeconomic status, marital status, history of medical conditions, country of origin, and years lived in the U.S. were analyzed with Statistical Package for Social Sciences software (SPSS) version 19.

The data were analyzed and discussed with a university professor of research methodology of Hispanic ethnicity. For this study, the researcher conducted member checks by verbally presenting a summary of the interview to the interviewees at the end of each interview. The descriptions of depression were confirmed by the participants contributing to the accuracy of the data and credibility of this study. Also, a summary of findings was shared with 10 participants individually (5 low-acculturated and 5 high-acculturated) to review and verify the data, interpretation, and to confirm preliminary research findings (i.e., member checking) (Lincoln & Guba, 1985). Participants reviewed and confirmed that the study findings reflected their understanding of depression. Finally, the ability to evaluate the research as unbiased and reliable was achieved by discussing the data, methodology, analysis process, and findings with professionals who have worked with members of the target population for many years (a retired Cuban-born physician, a pastor and family counselor from the Hispanic community in Miami, and a Colombian-born psychologist). These individuals were asked for their insight related to the consistency and applicability of the findings (Lincoln & Guba, 1985). The retired physician felt that the analysis and findings were credible, based on his extensive experience with the population. The Colombian psychologist agreed that the analysis and results captured the characteristics that she has observed in her own practice. The pastor concurred with the process and findings indicated in this study.

RESULTS

Table 1 displays the sample characteristics. Twenty-eight females and twenty-two males comprised the sample for this study. Participants' country of origin varied, 46% were Cubans ($N = 23$), 30% were Puerto Ricans ($N = 15$), and 24 % were South Americans ($N = 12$) (seven Colombians and five Venezuelans). The average years living in the United States was 37. Low-acculturated participants ($N = 25$) spoke Spanish, and high-acculturated participants ($N = 25$) spoke English and Spanish.

Older Hispanics' Explanatory Model of Depression

The major finding revealed that there were more similarities than differences in the descriptions of depression reported by participants from the three Hispanic subgroups, a finding similar to another study

Table 1
Demographics of Sample.

	Frequency, n	Percentage, %
Gender		
Female	28	56
Male	22	44
Age		
M = 64.26, SD = 8.36		
55–64	30	60
65–74	13	26
>74	7	14
Education		
M = 13.90, SD = 3.66		
K – 12 grade	22	44
College (2 years)	11	22
BS	6	12
Graduate	11	22
Income		
M = 39,480, SD = 23,226		
Median	40,000	
Marital status		
Married	41	82
Divorced	5	10
Single (never married)	1	2
Widow/Widower	3	6
Medical history		
Hypertension	10	20
Other (diabetes, thyroid disease, asthma, cancer)	22	44
None	18	36
Cuba	23	46
Puerto Rico	15	30
South America (Colombia & Venezuela)	12	24
Years lived in the U.S.		
M = 37.44, SD = 16.56		
1–20	7	14
21–40	19	38
41–60	19	28
>60	5	20
Place of birth		
U.S.	5	10
Outside of the U.S.	45	90

exploring cultural models of depression among Hispanic groups in Florida (Martinez Tyson, Castañeda, Porter, Quiroz, & Carrion, 2011). Six themes emerged that comprise older Hispanics' explanatory model of depression as well as their explanations of causes, effects, and treatment preferences. The six themes that emerged were: preference for lay terminology, depression as personal weakness, depression attributed to life stressors, stigma associated with depression, reluctance to seek mental health care, and centrality of family and religion.

Preference for Lay Terminology

Participants were first asked to name the presenting problem after reading a case vignette describing a person exhibiting depressive symptoms. Participants used a variety of emic terms and local explanations to describe the problem. For example, a low-aculturated 66 years-old female said, "That person worries too much because of their children, health, or lack of money." Furthermore, most participants recognized that the problem was depression; however, they were quick to explain that depression was the term used in "this country" – the United States. Responses from two high-aculturated men are as follows:

They call it depression here...but I think that what happens is that some people become unproductive because they don't have anything better to do. You need to keep yourself busy to forget any problems you may have.

I know some people who have depression. That's what they tell you here...but to me...That is nonsense...A person who complains about everything...Those people end up doing drugs or something worse. They just don't see the positive in life.

In general, there was hesitation among participants on how to name this conglomeration of symptoms from the vignette using just one Spanish term. A low-aculturated 58 years-old male participant stated "That person is bored and comes up with some sort of illnesses." Several low and high-aculturated participants explained that in their native countries this condition was attributed to people who were mentally unfit. A 64 years-old Colombian participant specified, "In my country, people say the person is crazy." Similarly, a 60 years-old Cuban participant reported, "Those people are considered crazy in Cuba and they get locked up in a hospital for crazy people." Also, a cultural idiom of distress, "nerves" was commonly used by participants to make sense of the vignette. A 67 years-old Puerto-Rican female participant explained, "We think it's a problem of the nerves." Similarly, a 62 years-old participant from Cuba said, "That person is having a nervous breakdown." A 62 years-old depressed participant summarized the problem from the vignette this way:

I don't know; they just call it depression here. I went to see my doctor because I was feeling so sick and tired and all they do is to give you medications that do not help. You kinda feel sick all the time and everything is going bad for you. Doctors keep telling you that they can't find anything wrong with you. People around you don't understand. They think you are going crazy and you worry all the time about what this is doing to your family but you can't help it.

Depression as Personal Weakness

To better understand how participants made sense of the case presented in the vignette, questions about the cause, effects, and coping strategies were asked. A 70-years-old low-aculturated female participant said, "Those are weak people who cannot face reality; you have to learn how to keep going." Terms commonly used by non-depressed high and low-aculturated individuals in response to the vignette were:

That is a weak person; a person who has a lack of desire to be motivated to do things; the problem is a lack of personal strength; that person doesn't know how to face problems; that person is not handling things well; it shows a pessimistic person, and the problem is people who fail to accomplish personal responsibilities.

Depressed participants had their own explanations and perceptions of depression after reading the vignette. One 64-years-old female participant said, "I was overwhelmed just like that person from the vignette. I did not have the strength to go on. It was too much for me but things are better now." Another 66-years-old depressed female participant pointed out, "Things happen; you know...I felt the same way...I couldn't handle everything that was going on in my life at that time." A few churchgoing participants believed that the problem from the vignette was a spiritual problem. For instance, a 60-years-old male participant said, "That person doesn't have a deep faith in God." Another participant said, "He has a spiritual disorder."

Depression Attributed to Life Stressors

Depression was also attributed to life stressors by most participants. One stressor described by participants was the language barrier or difficulty communicating in English. A 68-years-old female participant stated, "The language difference is traumatizing; it is more difficult when you are old." A similar comment was made by a Colombian female

participant who tried to live in Broward County for a couple of years, “I felt lonely...I couldn’t talk to anyone, so I moved back to Miami.”

The changes faced by recent immigrants, who are older adults, were considered difficult and stressful. A low-acclulturated 64-years-old depressed participant stated, “I was too old when I came and don’t know how to drive. I cannot go anywhere by myself. I have to wait for my daughter to take me everywhere and translate for me...I feel so helpless.” A 62-year-old woman, who has been in the U.S. for just one year, expressed:

I left my house in Colombia to come here to help my daughter by taking care of my grandchildren. She got divorced and needs help with the children. It is hard to live here...Everything is so different, the language, the values...But I don’t want my grandchildren to be raised by strangers.

Other stressors contributing to depression included financial difficulties, loss or lack of a job, inability to work and a related fear of becoming a burden to society, and unfamiliarity and incompatibility with the new society’s values. A high-acclulturated 71-years-old former teacher expressed distress by saying, “The culture is different; older people go to nursing homes to die. I cared for my mother at home until she died. It is not the same here; our children and society are too busy for the elderly.” Another depressed high-acclulturated participant stated, “Older people are forgotten here; they are left to die in nursing homes. There is no time for family. It is just the way it is here.”

Life stressors such as chronic illnesses, disability, and other health challenges older adults face were given as reasons for depression. For example, a low-acclulturated 63-years-old depressed widower said, “When you get old, things happen you know; I got diabetes and now I can’t see well. My neighbor drives me to church.” Finally, family disruptions and conflicts including separation from family members (nuclear and extended family) to come to the U.S., divorce, death of a loved one, and conflicts in values between parents and adult children were also perceived as life stressors contributing to depression. For example, a 59-years-old female participant, who has grown up children and grandchildren born in the U.S., expressed, “Our children’s values are different here; they work constantly to achieve material things and have no time for family, much less for old people. In our country, we care for the oldest at home.”

Stigma Associated With Depression

The stigma associated with depression was noticeable throughout the interviews. Depression had negative connotations and was a source of shame according to participants. A high-acclulturated 64-years-old female stated, “Depression has not been advertised as a good thing. It’s like you have something wrong with your head. I’m a positive person but when I think of mental illness or depression, it is not so positive... When I hear that someone is depressed, I think the person is a mental case.” Also, a high-acclulturated 62-years-old Colombian male explained it as follows:

It is taboo among Colombians. People think this person is going crazy. Nobody talks about it. Here, it is something that needs to be addressed and people take medications for it...Maybe, people will revisit their perspectives with more education about it.

At times some participants implied that the individual is responsible for his or her own depressive symptoms. A high-acclulturated 59-years-old participant mentioned, “I think this person put himself in a no-win situation and he does not want to find a solution to his problems. All he needs to do is to face his problems.” Some participants also believed depression could be a temporary situation, and finding the solution to the problems, or the ability and willingness of the individual to handle these problems appropriately could lead to improvement. “People allow the problems to control them and rule their lives. It

depends on the individual’s ability to come out of it,” one low-acclulturated 63-years-old participant said.

Depression was a source of familial shame for participants who feared the impact depression would have on their families. For instance, a high-acclulturated 55-years-old male participant said, “I fear I won’t be able to provide and do things for my family if I am in that situation.” Other participants thought depression would be the same as failing to meet their families’ expectations and disappointing them. A sixty-eight years old female depressed-participant said, “My family thought I was a hypochondriac and I felt I was not worthy and was failing them.”

Reluctance to Seek Mental Health Care

When participants were asked if they would seek help from mental health care professionals for the problem described in the vignette, many of them responded with the reasons why they would not seek help from mental health professionals and medical treatment for depression. The belief that the role of mental health providers is to prescribe addictive medications for treating “crazy people” was the most common reason given by several participants in both the high and low-acclulturated groups for not seeking help from mental health professionals. For example, a low-acclulturated 62-years-old participant explained, “No, we Latinos don’t give work to the psychiatrists; psychiatrists treat crazy people.” Furthermore, one participant did not see the need for mental health professionals, “There is no need for doctors; the person can overcome it by himself by refocusing and changing priorities.” Another 63-years-old male participant had a similar opinion, “It depends on the individual; everyone is different. You can either face your problems or drown with them.”

Medical treatment was considered a last resort for some participants. A high-acclulturated 64-year-old male participant expressed, “Well...only in a severe case, if I become suicidal, I would take the meds.” One low-acclulturated 62-years-old female participant stated, “Medications treat the symptoms and not the problem.” Participants also expressed fear of dependency on drugs and a preference for a more holistic approach. They also mentioned that they would rather try home remedies before seeking mental health services. For example, a high-acclulturated 56-years-old female participant said, “We have been raised using home remedies (e.g. linden or chamomile tea) instead of taking pills for everything.” Several participants who had been treated for depression stopped taking the medications because of adverse side effects. “Medications side effects are worse than the problem,” a depressed 60-years-old female participant said. Also, a high-acclulturated 61-years-old depressed participant said, “Medications make you hallucinate and lose your mind...It will totally mess up your head.” Medication was not perceived as the solution to the problem. A depressed 65-years-old participant recounted her experience with antidepressants:

When I started taking the medications for depression, I would be standing in front of the refrigerator and did not know what for. My mind would go blank. I felt like a zombie. Then, I stopped taking them and felt better.

Participants prefer to be given choices and opportunities and to be taught how to better handle difficult situations instead of being given a prescription right away. They said they valued the opportunity to voice and receive guidance for their problems. For instance, a depressed 67-years-old female participant said, “Sometimes you just need somebody who understands what you are going through; just someone you can talk to.” Another non-depressed, high-acclulturated participant said, “People need help; they need guidance to handle their problems. They don’t know what to do.”

Centrality of Family and Religion

As life becomes more stressful, participants cope with their problems by relying on family and religious beliefs. They relied on

family and religion for emotional support, help, and well-being. In general, they shared a sense of pride, belonging, and obligation to the members of the family. Essentially, the value placed on the family involved the obligation to care for older parents at home, providing emotional and financial support, and making decisions that affect them (e.g. health care, financial decisions). For instance, a low-acculturated 58-years-old female participant stated, “My mother died at home. I cared for and did everything for her. We believe that the children should have respect for and take responsibility for their elders.”

Family was indispensable to participants from this study. “Having a strong family relationship determines the well-being,” according to a high-acculturated 62-years-old female participant. On the other hand, a lack of a strong family connection and family conflicts can be a major reason for distress. A low-acculturated 64-years-old participant explained, “In the U.S., family changes and is divided; children grow up with different values.” One seventy-six years old participant’s major fear was to be placed in a nursing home and “to be forgotten by my family.” Furthermore, having family around most of the time and participating in the family’s day to day issues keeps older Hispanics alive and with a sense of purpose. A high-acculturated 60-years-old male participant explained:

Family is very important to us; we grew up surrounded by family, cousins, nephews; we keep in touch with each other...I mean everyone, grandchildren, extended family; we are always concerned about family and when we have parties we have 50 people in our house. That is how we were brought up.

Religion was identified as a vital part of having good mental health and feeling well by participants. There was a reliance on religious activities and having religious beliefs for good mental health. For example, one high-acculturated sixty-two years old participant stated, “You need some type of religion to be mentally healthy; having faith in God is very important to have good mental health.” Furthermore, many participants used religion as a coping mechanism for stress. For instance, a depressed-participant stated, “You have to keep praying to deal with life challenges; that’s the only thing that helps.”

Comparison of the Explanatory Models of Depression Among Hispanics

This section answers the research question, Is there a difference in the explanatory models of depression between high and low-acculturated, depressed and non-depressed Hispanics? A comparison of depressed and non-depressed and high and low-acculturated Hispanics’ accounts of their depressive symptoms is presented.

Comparison Between Depressed and Non-depressed Participants

A comparison of depressed with non-depressed participants’ accounts of depression indicates that participants’ views of the problem, causes, symptoms, coping, and treatment preferences were mostly similar. However, a difference in their explanations related to the causality of depression is noteworthy. Depressed participants viewed the cause of depression primarily as life stressors and as their own lack of ability to sometimes handle these stressors. The eleven depressed participants admitted their helplessness associated with the development of depressive symptoms and their inability to overcome depression. For instance, a 62-years-old female depressed participant stated, “I was overwhelmed by everything that was happening to me... did not know what to do or how to come out of it.” A male depressed participant said, “I don’t know what would have happened to me if it wasn’t for my wife. She kept me going.”

Non-depressed participants viewed the causes of depression to be life stressors and the individual’s fault for feeling depressed. They believed it depended on the individual’s ability to get depressed and to overcome depressive symptoms. The depressed individual was seen, in part, as responsible for his/her depression. A high-acculturated

59-years-old male participant stated, “Those are people who have learned to get depressed due to life experiences. They are not able to solve problems and get easily overwhelmed.” They expressed that it is up to the individual’s own strength to come out of depression. Many saw depression as an individual choice. One low-acculturated female participant said, “People don’t want to face their problems and be responsible.”

Comparison Between High and Low-Acculturated Participants

A comparison of high-acculturated with low-acculturated participants’ accounts of depressive symptoms revealed more agreement than disagreement among high and low acculturated participants regarding their explanations of depression. There are only two noticeable differences in their explanations of depression. First, some high-acculturated participants were more willing to seek care from mental health providers if needed. For example, a 68-year-old male stated, “If I can’t handle it...only in a severe case... I’ll probably start with counseling. I prefer counselors who have my same values because psychiatrists just give you pills.” Second, unlike their low-acculturated peers, high-acculturated older adult Hispanics in this study do not believe they experience challenges and stressors differently from the mainstream American culture. Most stressors are seen as unrelated to cultural identity. For instance, a black male Hispanic said, “I don’t experience any challenges for being Puerto Rican; I’ve been discriminated because of my skin color and not because I’m Puerto Rican, even by Hispanics.”

The majority of low-acculturated participants were reluctant to consider seeking mental health care for depression. Several participants described their unwillingness to seek care and treatment from mental health care providers. “I don’t trust psychologists and psychiatrists...I don’t have faith in them,” a low-acculturated female stated. Another 57-years-old participant expressed, “Doctors just give you meds and we don’t rely as much on medications because of the side effects.” Furthermore, low-acculturated participants believe that many life stressors and challenges they face are unique to them and are related to their cultural identity and immigration status. For example, the language barrier and differences in values between parents and children are a great source of distress. Participants expect their children to care for them when they get older. A female Cuban participant stated, “In our country, we care for older people at home. Here, your children grow up and forget you.” Conflicts between the different generations in the home were mentioned by some low-acculturated participants. “The children are raised differently here; they don’t have our same values.” They are more dependent than high-acculturated participants on family support and care as they age.

Conceptual Model

This study revealed a shared explanatory model of depression among older Hispanics. Participants did not view depression as an illness or medical condition, but as the result of life stressors and personal weakness. Depression carried negative connotations such as lack of personal strength, making depression the individual’s fault. These connotations contribute to the stigmatization of depression in the Hispanic community, which in turn influence the experience of depression and coping strategies. Because of the stigma associated with depression counseling and life skills training were seen by participants as more appropriate than medication and mental health treatment.

Fig. 1 illustrates Older Hispanics’ Explanatory Model of Depression. Circles represent older Hispanics’ distinctive view of depression. The white inner circle represents the emphasis on internal causes of depression (personal weakness). The outermost circle refers to participants’ perceived external causes of depression (life stressors: social, relational, health factors). Taken together these two circles (external and internal causations of depression) influence coping strategies—reliance on family and religious support. The right side of

the middle circle illustrates treatment preferences, which include counseling and life skills training, to alleviate stressors. The dashed lines on either side of the central model indicate that stigma serves as a barrier between older Hispanics and their willingness to accept medical treatment and access mental health care interventions for depression.

Implications for Nursing Practice

Older Hispanics have been reported to be at increased risk for under diagnosis and treatment of depression (Fernandez-Garcia, Franks, Jerant, Bell, & Kravitz, 2011). Overall very few older Hispanic adults are ever treated for depression and their access to care comes mostly from primary care settings (Interian, Ang, Gara, Rodriguez, & Vega, 2011). This study also revealed important insights about the cultural and social dynamics that shape older adult Hispanics' understanding of depression and treatment choices. Findings indicated that older Hispanics viewed depression as a result of life stressors and personal weakness. These results support the incorporation of culture-based approaches to improve clinical outcomes and quality of life.

Hispanics preferences for counseling, non-traditional medicine, and life and stress management skills training seem to be linked to the predominant stigma related to mental illness and a lack of understanding regarding treatment. Counseling that provides a context for sharing emotions, building supportive relationships and acquiring new skills to cope with life stressors, therefore, would fit with Hispanics' conceptions of depression. Medications, on the other hand, are less congruent with older Hispanics' model of depression. Eisdorfer et al. (2003) reported that for Cuban Americans, family therapy and Internet-supported interventions significantly decreased caregiver burden, thus reducing the risk for depression. The improvements were maintained for 18 months after the intervention was concluded. Furthermore, Cabassa, Hansen, Palinkas, and Ell (2008) reported that therapy provided a way of releasing emotions and coping with problems, therefore helping depressed Hispanic participants to feel less isolated. Martinez Tyson et al. (2011) found that talking to someone was highly desirable among participants and helped Hispanics feel relief. Counseling that focuses on helping older Hispanics learn skills to navigate through an unfamiliar environment, manage the stressors resulting from recent immigration, and cope with losses

and conflicts also may help prevent depression by providing the skills to mediate its occurrence.

It is important to consider the reasons for under treatment, including discontinuation of medications, misdiagnosis, ongoing and unaddressed psychosocial stressors, and depression responsive to another class of medication. These findings also suggest that structured medication management programs that actively address patients' concerns and fears about medications, engage patients into treatment, and provide ongoing support and monitoring may reduce treatment drop-out and non-compliance among older Hispanics.

Incorporating Familism into the Plan of Care

Given the importance of familism and the role of the family among Hispanics, health care providers must consider the unique life experience and family dynamics of the Hispanic family to attempt to deal with depression within this community. The importance of caregivers and interdependence among family members must be recognized for successful treatment of depression and to provide culturally sensitive care.

Cultural forms of resilience such as familism can be used to enhance understanding of depression and treatment participation among Hispanic communities. The interrelationships and role expectations among older Hispanics and their family members deserve careful consideration. Incorporating them into the assessment and treatment process is important. Older Hispanics, who are not familiar with the health care system, may rely quite heavily on adult children to seek help and to make health care decisions for them. Family members may help to enhance compliance with treatment. Community level interventions, promoting family involvement and social support systems, and increasing knowledge and skills related to the language and lifestyle in the U.S. can be viable prevention strategies at the individual and household levels. In addition, the stressors related to the process of acculturation (e.g., language barrier, family disruptions, health issues, etc.) should be included in the assessment for depression to identify factors that may trigger the development of depression (Sadule-Rios, 2012). It is essential to find problem definitions and therapeutic strategies meaningful and acceptable to patients, families, and clinicians.

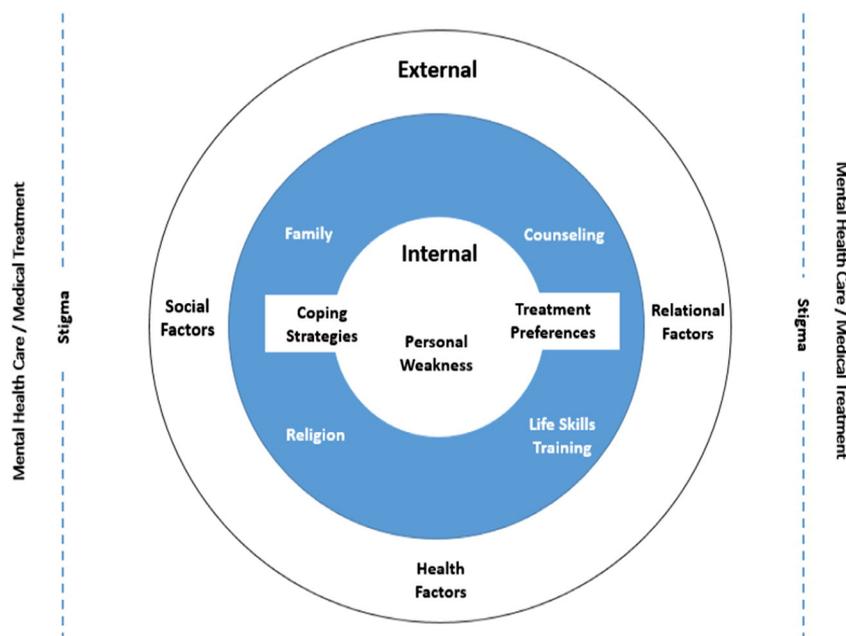


Fig. 1. Older Hispanics' Explanatory Model of Depression.

Limitations of the Study

This study involved interviews with Hispanics in South Florida. The sample was not random, but purposive – based on preset criteria. The sample reflects diversity of Hispanics in South Florida but not in other parts of the country. Therefore, the findings of this study are not generalizable. The qualitative nature of this inquiry also precludes the assumption that the findings are generalizable. Future research might focus on other regions of the country with a more diverse group. However, the sample of 50 participants included representatives of the three largest Hispanic groups in Florida, one of the top three states with large Hispanic populations (U.S. Census Bureau, 2010), suggests that the findings can inform education and practice statewide.

The interview method itself posed another limitation, in that the questions and vignette could have impacted responses. Responses also may have been impacted by faulty memories or interviewees' reluctance to disclose personal information (Patton, 2002). The questions were, however, informed by the conceptual framework and the extant literature on the topic. Furthermore, the interview method is also a strength in that the process elicited deep insight from all participants.

CONCLUSIONS

The medical concept of depression is a psychiatric condition characterized by specific affective, cognitive, behavioral, and somatic symptoms (5th edition; DSM-V; American Psychiatric Association, 2013). Although people from different cultural backgrounds may describe depressive symptoms with terms very different from the American Psychiatry Academy's definition, few studies have explored the conceptualization of depression among various cultural groups, particularly Hispanics.

The results indicated that Older Hispanics' conceptualization of depression differs significantly from contemporary biomedical and psychiatric models of depression and highlights how social and cultural dimensions of illness are important in shaping Hispanics' explanatory model of depression. The findings suggest that older Hispanics' depressive symptoms are associated with life stressors and personal characteristics and weaknesses – boredom, problems of the nerves, craziness, and worrisome nature. These culturally coded terms may confound diagnosis among many Hispanics, both low and high-aculturated individuals, who find depression unacceptable and shameful. Older adult Hispanics prefer professionals with similar values and beliefs and non-traditional treatments. The benefits of cultural concordance may be of particular importance to this group that was so concerned about stigma, stereotyping, and medication dependency.

This study provides rich insight into older Hispanics' perspectives about depression and has implications for nurses and other healthcare providers in all settings who may encounter older Hispanics with depression. Exploration of Hispanics' explanatory models about depression by practitioners is needed to ascertain complex information about social triggers of depression, health seeking behaviors, and perceptions to better inform practice and treatment outcomes. This study highlights the complexity and diversity of this group of older Hispanics' conceptual model of depression. Further studies are needed to confirm if there is indeed a shared explanatory model of depression among older Hispanics in other parts of the country where the Hispanic population may vary from the sample in this study.

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