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"Feeling blue" in Spanish: A qualitative inquiry of depression among Mexican immigrants

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ABSTRACT

Studies of the cultural construction of depression among Mexican immigrant men in the USA are rare. This paper is a qualitative inquiry into how this population of men identifies depression and its perceived causes and remedies. Data were gathered from seven focus groups with a total of 38 adult Mexican immigrant men. Results indicate that *depresión* (depression) is a valid and familiar concept among this group. While the reporting of somatic symptoms does occur, it appears that interpersonal problems and affective symptoms are among the most salient in identifying someone as depressed. The causes are described as predominantly social in origin, arising directly out of the participants' experiences of immigration and adaptation. Similarly, the proposed remedies are primarily social in nature with an emphasis being put on help from the community, the family, or a professional. Colloquial terms are provided in both Spanish and English and direct quotes from the focus group discussions are included.

Introduction

Latino immigrants to the United States, a majority of whom are from Mexico, are less likely than either US-born Latinos or White Americans to access mental health care when they are depressed (Vega et al., 1998). Recent research has suggested that low rates of treatment seeking may be partially a result of differences in conceptual models of depression across cultural groups (Cabassa, Lester, & Zayas, 2007; Karasz, 2005; Pincay & Guarnaccia, 2007). Factor analyses of depressive symptomology scales support the claim that there are different conceptual models for Mexican Americans versus Anglo Americans, a finding that is likely to hold true for Mexican immigrants as well (Crockett, Randall, Russell, & Driscoll, 2003; Guarnaccia, Rivera, & Worobey, 1989). However, without going beyond the indicators on these scales it is not known to what degree the concepts overlap or what omitted culturally specific indicators or language may be involved. One of the concerns is that if the models used by Mexican immigrants to self-assess their mental health are different from those that practitioners use, there will be a greater difference between those who might need care and those who perceive a need for it. Moreover, if the treatment clinicians provide differs too widely from the treatment a Mexican immigrant expects, then he/she may reject the help all together. Greater knowledge about these cultural conceptions, coupled with increased outreach into Mexican immigrant communities, may allow mental health practitioners to better serve this population.

The goal of this research is to explore five aspects of the cultural conceptions surrounding depression among Mexican immigrant men: identification of depression, symptom presentation, perceived causes, suggested remedies, and colloquial terminology. Responses from 38 participants in seven focus groups are transcribed, translated, and analyzed. Due to space constraints, many long quotations are provided only in English, but Spanish translations are available from the author. All key words are provided in Spanish with English translations, including all symptoms presented

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in the tables. This information may be used to improve existing models of culturally competent care available to Mexican immigrant men, as well as screener scales used to study depression in this population.

Concepts are rarely invariant across different cultural groups, and the fact that depression also varies is not a novel observation (Jadhav, Weiss, & Littlewood, 2001; Kleinman, 1977; Schwartz & Schwartz, 1993; Weiss, Jadhav, Raguram, Vounatsou, & Littlewood, 2001). A cultural group, as the term is used in this paper, refers to a group of people who share norms, values, beliefs, and behaviors (DiMaggio, 1997; Silber, 2003). Of particular interest is how this shared cultural information shapes the way people in a particular group think about illness and healing behavior. One way people use culture is as a schema for filtering symptoms into categories like normal versus abnormal, socially acceptable versus stigmatized, and non-threatening versus serious (Angel & Thoits, 1987; Baarnhielm, 2004; Canino, Lewis-Fernández, & Bravo, 1997). More importantly, all people are embedded within some cultural context, even mental health practitioners and researchers.

Cultural competence

Being aware of cultural information and successfully incorporating it into clinical settings is broadly referred to as cultural competence (Carrillo, Green, & Betancourt, 1999; Redmond, Rooney, & Bishop, 2006; US Health Resources Services Administration, 2006). The culturally competent clinician or researcher should be aware of the specific language used to describe the illness and negotiate the treatment (Carrillo et al., 1999). In addition, it is important for clinicians and researchers to attend to culturally specific stigmas and symptom presentations of the illness, as well as beliefs about illness etiology (Lewis-Fernández, Das, Alfonso, Weissman, & Olfson, 2005; US Health Resources Services Administration, 2006). One way of defining a culturally competent clinician or researcher is a clinician who is aware of multiple levels of interpretation (Koss-Chioino, 1992). Koss-Chioino (1992) defines these multiple levels as the *mental health* view, the *folk healing* view, and the *patient's* view. For example, using a *mental health* view, a Puerto Rican woman may explain her depression as caused by a disordered mind, behavior, or lifestyle. From a *folk healing* view, the woman may explain the depression as an obsession caused by some external force. Yet, if describing the depression to non-clinicians the woman may use a *patient's* view, attributing it to problems with her husband or children. While Koss-Chioino's (1992) research was on Puerto Rican women, the notion that patients may apply different cognitive schemas to express their illness is an important one. The challenge for a clinician or researcher, then, is to understand the specific ways in which culture affects these schemas.

The awareness of the need for culturally competent care has grown over the last decade (Lewis-Fernández & Díaz, 2002; Redmond et al., 2006). One of the biggest developments in the scholarship on cultural competence was the formation of the *Group on Culture and Diagnosis* in 1991. Research efforts that began in this group lead to the creation of the *Cultural Formulation Model* as one culturally competent way for practitioners to assess the mental health of clients from different cultural backgrounds (Lewis-Fernández & Díaz, 2002; Lewis-Fernández et al., 2005). Unfortunately, as US Department of Health and Human Services (2001) report put it, "[cultural competence] has been promoted largely on the basis of humanistic values and intuitive sensibility rather than empirical evidence" (p. 36).

Previous research

Over the last 30 years, the research on depression among Mexican immigrants has explored two important areas related to the cultural conceptions of depression.

1. The relationship between depression and somatization (e.g., the physical presentation of psychological symptoms) (Angel & Guarnaccia, 1989; Canino, Rubio-Stipec, Canino, & Escobar, 1992; De Gucht & Fischler, 2002; Ruiz, 1998);
2. the relationship between depression and *nervios* (nerves) (Baer et al., 2003; Guarnaccia, Rivera, Franco, & Neighbors, 1996; Liebowitz, Salmán, Jusino, & Garfinkel, 1994; Salgado De Snyder, Diaz-Perez, & Ojeda, 2000).

The research on somatization (i.e., the physical presentation of psychological symptoms) has challenged medicine's biological model of depression by demonstrating that there are significant social and cultural components to bodily perceptions (De Gucht & Fischler, 2002). Somatic symptoms of depression include headaches, stomach pains, and exhaustion (Angel & Guarnaccia, 1989; Ruiz, 1998), and the research provides strong evidence that somatization occurs among Spanish-speaking groups (Angel & Guarnaccia, 1989; Canino et al., 1992; Ruiz, 1998). This research could be expanded, however, to include investigations of how culture may influence the presentation of non-somatic symptoms such as interpersonal problems, depressed affect, and positive affect. More importantly, rather than substituting psychological symptoms for somatic ones, some cultural groups may have terms that refer to combinations of psychological and somatic symptoms. Attention will be paid to this possibility in analyzing the results.

The research on *nervios* (nerves) is important for understanding how certain Latino populations substitute cultural syndromes for more Western psychiatric disorders. Among Mexican immigrants, symptoms of *nervios* (nerves) or *un ataque de nervios* (nervous attack) are similar, but not identical to those of depression; they include verbal outbursts, crying, trembling, aggression, suicidal gestures, and fainting (Guarnaccia et al., 1996). Studies have uncovered evidence of this syndrome among Mexican American, Mexican, Puerto Rican, and Guatemalan populations (Baer et al., 2003; Guarnaccia et al., 1996; Liebowitz et al., 1994; Salgado De Snyder et al., 2000). Originally theorized as an explanation for high levels of somatized symptoms of depression reported by Spanish-speaking populations, it is now understood that *nervios* or *un ataque de nervios* can present in isolation as a separate somatic disorder or comorbidly with depression (Salgado De Snyder et al., 2000). In fact, a prevalence study among a rural sample of people in Mexico shows that at most 7.1% of men present comorbidly with depressive symptoms and *nervios*, while 3.3% present only with depressive