

“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 are rare. This paper is a qualitative inquiry into how this population of men identifies depression and its perceived causes and remedies. Data are 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, 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, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 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 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; G. 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 (Carillo, Green & Betancourt, 1999; US Health Resources Services Administration, 2006; Redmond, Rooney, & Bishop, 2006). The culturally competent clinician or researcher should be aware of the specific language used to describe the illness and negotiate the treatment (Carillo, Green & Betancourt 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 et al., 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, Rooney & Bishop, 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 a 2001 US Department of Health and Human Services report put it, “[cultural competence] has been promoted largely on the basis of humanistic values and intuitive sensibility rather than empirical evidence.” (pg. 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; I. A. Canino, Rubio-Stipec, Canino, & Escobar, 1992; De Gucht & Fischler, 2002; Ruiz, 1998)
2. the relationship between depression and *nervios* (nerves) (Baer, Weller, Garcia De Alba Garcia, Glazer, Trotter, Pachter 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 (Ruiz, 1998; Angel & Guarnaccia, 1989), and the research provides strong evidence that somatization occurs among Spanish-speaking groups (Angel & Guarnaccia, 1989; I. A. 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 symptomology (Salgado De Snyder et al., 2000). The qualitative inquires into *nervios* can be enhanced by conducting similar inquiries into depression. Having both will better inform our understanding of when a diagnosis of *nervios* versus a diagnosis of depression is appropriate. Distinguishing between both disorders and a comorbid disorder is also important for researchers who want to conduct studies of mental health trends in this population. This study offers some suggestive findings about which symptoms may be jointly related to the two disorders, but given the small sample size, these are only suggestive.

METHODOLOGY

A qualitative inquiry of depression was conducted using data collected from seven focus groups with a total of 38 adult Mexican immigrant men. Focus groups have also been used in select cases to explore lay attitudes on depression (Pincay & Guarnaccia, 2007; Priest, Vize, Roberts, Roberts, & Tylee, 1996), stigmatization of depression (Prior, Wood, Lewis, & Pill, 2003), and anti-depressant prescribing behavior among general practitioners (Hyde, Calnan,

Prior, Lewis, Kessler, & Sharp, 2005). These conversations provide an opportunity for respondents to explore their own thoughts relative to others, thus giving insight on the way depression is discussed, applied, and stigmatized in groups. That said, there are drawbacks to data gathered from group conversations such as “group think” and “domineering participants,” but careful attention by the moderator can mitigate these influences. For a more detailed discussion of focus groups see: (Litosseliti, 2003).

Participant selection - Mexican men are an important subset of US immigrants to study because they make up a large segment of the US immigrant population (US Census Bureau 2000) and little is known about the cultural context of depression in this community. Studies of depression among only men are rare, but concepts of depression may differ by gender. I focus only on men to hold constant the possible variations by gender. To control for differences in bilingual ability and years in the US, each participant filled out a brief acculturation scale (Marín & Marín, 1991) and demographic information sheet prior to beginning the focus group. Table 1 shows the resulting demographic characteristics for each group.

(“Table 1”)

To successfully recruit participants from the semi-closed Mexican immigrant communities, a snowball sampling methodology was used. A few people were contacted who worked at community centers, work places, churches, and health organizations in North Carolina that were frequented by Spanish-speaking immigrants. These contacts agreed to help recruit people who fit the selection criteria. To broaden the sample, an ad was placed in a widely distributed Spanish-language newspaper. This resulted in almost a third of the final sample coming from outside the church, work place, and community center circles. The final focus groups were comprised of 9 participants who responded to the ad in the newspaper, 10

participants from community centers, 13 participants from church groups, and 6 participants from work places.

Questioning guide design – The author moderated and transcribed all of the focus groups in Spanish. The focus group sessions lasted approximately 80 minutes from start to finish and began with a brief introductory section. The first task was to see whether the participants could successfully identify a Western conception of depression based off of the DSM-IV criteria. Data were generated through the use of a vignette describing a fictitious man from Mexico (Juan) who was exhibiting symptoms of a major depressive disorder. The vignette did not mention the term depression nor did the moderator use this term unless the men themselves came up with this interpretation. Instead, after reading the vignette the moderator asked the groups: “What do you think might be wrong with Juan?” At this point, none of the participants knew that they were going to be talking about depression, mental health, or cross-cultural differences. The focus groups were advertised more generally as a discussion about thoughts and feelings. A similar methodology and the same vignette were used with a structured interview format in a study by Cabassa, Lester, & Zayas (2007). The vignette was designed using DSM-IV criteria for a major depressive disorder (American Psychiatric Association 2000). In English it reads:

“Juan is a Mexican man with a High School Education. For the last several weeks Juan has been feeling really down. He wakes up in the morning with a sad mood and heavy feeling that sticks with him all day long. He isn’t enjoying things the way he normally would. In fact, nothing seems to give him pleasure. Even when good things happen, they don’t seem to make Juan happy. The smallest tasks are difficult to accomplish. He finds it hard to concentrate on anything. He feels out of energy, out of steam and cannot do things he usually does. And even though Juan feels tired, when night comes he can’t go to sleep. Juan feels pretty worthless, very discouraged, and guilty. Juan’s family has noticed that he has lost appetite and weight. He has pulled away from them and just doesn’t feel like talking.”

The conversation about the vignette was allowed to develop without moderator input. After it had ceased, “depression” was specifically mentioned by the moderator as a topic for discussion. The moderator asked: “Thinking about depression, what signs or indicators do you

think signal that a person is suffering from depression?” Later during the same activity, a series of hypothetical questions were posed: “Imagine that one of your friends (in this case a man) suffers from depression. How do you think you would discover this? That is, what about him would indicate that he was suffering from depression?” The third activity centered on discussing the causes of depression and the fourth activity centered on potential help-seeking behaviors. The last activity was a discussion of the colloquial terms used for the concept of depression.

Identifying depression

Overall, the groups did recognize Juan’s story as being about depression. A majority of the groups mentioned *deprimido/depresión* (depression) as being a possibility – groups 1, 2, 3, 4, and 7 – but at least two groups did not mention depression as a possibility at all – groups 5 and 6. In groups 5 and 6, the moderator moved the conversation to a discussion of depression by mentioning depression as a topic of interest at the start of the second activity. Also, in all of the groups there was a fair amount of hesitation when they were first asked to comment on Juan’s story. The reason for this initial hesitation among the groups is unclear. It may be a sign of reluctance about discussing such a topic or it may represent difficulty in identifying the characteristics of the Western conception of depression. Then again, it could simply be the result of the participants’ general unfamiliarity with focus groups. In all of the groups, however, the discussion became more animated the longer the conversation continued. Below are a few brief excerpts and descriptions from the beginning of each focus group.

In groups 1, 3, and 4, depression was mentioned immediately, but just as quickly someone else offered an alternative explanation emphasizing *estrés* (stress) or *triste/tristeza* (sadness). The conversations were allowed to develop naturally during the first few minutes and so once a topic like stress or sadness was mentioned, the conversation tended towards discussing

these issues. In group 4 the first respondent to speak seems confident that it is depression, but one of the other group members tries to back away from this diagnosis by emphasizing the possibility that it is just stress. Notice that in group 3, one of the participants seemed to be searching for the term depression, but had trouble remembering it. Moreover, no one else was able to offer him help with the word, but this seemed to be an isolated incident. Also, in groups 3 and 7, the participants did something very interesting; they imbued Juan's story with details that were never given in the vignette. That is, they explained what was occurring with Juan by citing examples of things that were never read, but that were *socially relevant to them*.

[GROUP 4]

Interviewer: Does anyone have an idea of what this paragraph represents?

P1: It is depression (*depresión*).

P2: Or...maybe it's stress (*estrés*) from working too much or always going to school or many things, stress comes from many things.

[GROUP 3]

Interviewer: Does anyone have an idea of what this paragraph represents?

P1: Well, it could be that he has some type of, how do you say it, when they have, it's, that they feel distant, that people don't understand them...ahh, depression! It could be that he has depression or some problem with his parents that no one understands.

Interviewer: Anyone else? Is everyone in agreement?

P2: No. In my opinion, I think that, that Juan is sad...sad because for the most part he is far from his family and is alone here.

[GROUP 7]

P1: Well, I believe it is depression...well, if like Juan you're here without your family it could be depression, but it could be another symptom.

P2: Yes, you are separated from your family.

P3: And...and you are not accustomed to the rhythm that, that other people have.

P1: The rhythm of life.

In group 1, depression was mentioned as a possibility, but someone also mentioned that he thought the symptoms could represent diabetes. Similarly, in group 2, the possibility that Juan was suffering from depression was raised, but the emphasis was on an internal illness of the stomach or head.

[GROUP 1]

Interviewer: Does anyone have any idea about what this paragraph represents?

P1: It could be depression...

Interviewer: And you would say that...

P2: Maybe he is suffering from depression because of his insomnia.

P3: Maybe he has symptoms of diabetes.

[GROUP 2]

“P1: I am [P1], I think that Juan is sick.

Interviewer: What type of sickness? Do you have an idea?

P1: Well, it's like a sickness of the...a very strong sickness like of the stomach or of the head, that you can't see. It is, the sickness is internal, it can't be seen. Or he could be very depressed also.

P2: My name is [P2]. When I hear Juan's story I believe that Juan suffers from a psychological illness. Or, a mental illness, because he thinks a lot, worries, and does not sleep.

In groups 5 and 6 the participants did not identify the passage as depression at all. Rather, they saw it as explaining some type of stigmatized illness like *drog adicción* (drug addiction), *SIDA* (AIDS), or Tuberculosis.

[GROUP 6]

P1: It could be drug addiction.

Interviewer: And you?

P2: [It could be] a very big problem that afflicts him that only he knows about.

P3: Yes, he has some doubt about some illness, and he doesn't want to tell his family

[GROUP 5]

P1: I think it represents AIDS.

P2: In my opinion that could be what he has, but it also could be tuberculosis.

Symptoms of depression

In total, the participants commonly identified 11 symptoms of depression, but they also mentioned at least three other symptoms that were not commonly identified. The Spanish-language symptoms identified by the groups along with their English translations and approximate DSM-IV symptoms, if any, are provided in Table 2.

(“Table 2”)

The groups discussed two positive affect symptoms: 1) *todo lo bueno lo ve malo* (everything good seems bad); and 2) *está viviendo por vivir porque ya no le interesa nada* (just living to live because nothing is interesting). Although the first phrase does not exactly match any symptom in the DSM-IV description, one could reasonably say that “everything good seems bad” is a “lack of pleasure” symptom. Similarly, “just living to live because nothing is interesting” closely resembles a “lack of interest.”

The groups also discussed three interpersonal symptoms: 1) *andaba retraída* (feeling withdrawn); 2) *ya no platica / no habla como antes* (not chatting anymore / not talking like before); and 3) *no quiere abrirse* (not “opening up”). These symptoms were mentioned in the second activity when the groups were asked how they would know a friend was suffering from depression. All of the groups mentioned these social indicators and therefore they may be very important in determining how fellow immigrants identify depression among one another.

Three somatic symptoms were commonly identified by the focus groups: 1) *falta hambre/falta apetito* (lack of hunger / lack of appetite); 2) *falta de dormir* (lack of sleep); and 3) *reduce el estado ánimo/sin ganas de hacer nada* (reduced energy / lack of energy to do

anything). The first two symptoms represent a more specific phrasing of symptoms like changes in sleep or eating. It appears that with these two symptom behaviors (i.e., eating and sleeping) it is under-indulgence that is seen as abnormal and not over-indulgence. The symptom of having less energy was described as someone lacking his/her normal animation and is similar to what is described in a Western conception of depression. In addition to these three commonly identified somatic symptoms, two groups (i.e., groups 2 and 4) mentioned *dolores del estomago* (stomach pains) and *dolores de la cabeza* (headaches), but these symptoms were not identified by any other group. Similarly one man in group 2 described the sensation of depression as being “*la sangre es la que está mal y viene la alarma al cerebro*” (it is bad blood that sends an alarm to the brain), but this was an isolated comment and was not repeated or discussed in any other group.

There were three depressed affect symptoms mentioned in the focus groups: 1) *triste / tristeza* (sad / sadness); 2) *se preocupa siempre* (constant worrying); and 3) *anda pensando / sigues pensando* (always thinking / thinking too much). Similar to how depressed affect symptoms are a central component to how a Western conception of depression is discussed; these three depressed affect symptoms were heavily emphasized by the participants. Feeling sad was the most frequently mentioned symptom in all of the focus groups, while the other two symptoms (i.e., “constant worrying” and “thinking too much”) were mentioned at least once by a member in all seven groups.

Two of these symptoms – worrying and thinking too much - were also closely related to one another. For example, as a participant from group 6 mentioned “*si piensa mucho se preocupa y no duerme*” (if a person thinks a lot, they worry, and they don’t sleep). It was alternatively described as thinking until one is worried or distressed, for example “*no más anda*

pensando...y por eso, hay muchas preocupaciones, se estresa uno” (nothing more than thinking, and therefore there are many worries, that stress a person out) (group 2). It is possible that the symptom of *anda pensando* (too much thinking) is another way of describing the DSM-IV symptoms of “difficulty thinking” or “difficulty concentrating,” but this assumption should be made with caution because there is no mention of worry or exhaustion from thinking in the DSM-IV conceptualization. In addition, the colloquial symptomology terms that are provided later in the paper emphasize a depressed affect interpretation of depression.

Causes of depression

Across the seven focus groups, six causes were consistently mentioned, all of which were psychosocial in nature and related directly to the immigrant experience in the U.S. That is, the Mexican immigrant men in the focus groups linked the development of depression in their community specifically to the environmental stressors in their environment.

One of the most often mentioned causes of depression, which was repeated by almost every *individual* in every group was separation from loved ones. This was especially true for those men who had left wives or girlfriends back home. One immigrant described the difficulties of being separated from loved ones in the following way:

[GROUP 2]

P6: There are people who, for example I am speaking of men who have their woman back in Mexico, they came here alone only to work, then the fact that their woman is back there in Mexico...well, they feel sad...they feel worse if they have children, if a friend dies and they cannot go back because of immigration [i.e., the border patrol]...it is many...there are many reasons.

Many of the Mexican immigrants also described discrimination and harassment as a cause of depression in the community. Specifically, they felt this discrimination occurred because of language barriers and inequalities in pay. As one person describes it:

[GROUP 4]

P2: Many people, especially Hispanic people suffer from depression here because sometimes they are discriminated against, because they don't speak English, they go to certain places and people don't understand them.

Participants also felt that the long hours and multiple jobs that they endured in the United States led to depression. Too much work, they argued, inhibited their ability to engage in stress-relieving behavior. A participant in one of the groups summarized this cause of depression by providing an example of what he used to do after work back in Mexico:

[GROUP 5]

P5: If you have free time you spend it working, working, from work to home, nothing else. And that stress is kept inside, too much in side. In my country, I went from work, to take a bath, and change clothes to go walk around in the streets or visit family or friends. In this way one is relieving stress. But here, no.

In contrast, the men also identified not having a job or receiving bad pay as a cause of depression because it prevented them from taking care of their needs such as sending remittances (i.e., monetary gifts) back home to their families. For example, one person describes how not having a job prevents one from taking care of his needs like this:

[GROUP 1]

P3: It depends. If you have a good job opportunity, you can take care of your needs. Or if you don't have a good job, you can't take care of your needs. And that may lead to a type of depression.

The men in the focus groups also revealed that even when surrounded by other immigrants, there was a feeling of social isolation. While there did not seem to be any distrust of other immigrants expressed, there was an acknowledgement that friendship was hard to develop because of a lack of mutual understanding and perceived competition. One man described the situation among roommates as follows:

[GROUP 4]

P4: Depression many times also comes from the lack of understanding from people. Many times you arrive in the United States and you meet a group of people who you don't know, that live five or six in one apartment, and you don't know these people or you don't know them very closely, even though they are compatriots, of our country.... And what happens? What happens when someone lives and works with these people 100% of the time, but does not have the same closeness as back in my country? Well, there comes a time when there is competition.

The last cause of depression, change in drug or alcohol use, was raised in all seven focus groups and addresses a larger concern in the literature over the high comorbidity between depression and alcoholism among male Hispanics. Studies have consistently shown that rates of substance abuse are linked with rates of mental disorders, including depression. Moreover, heavy drinking has consistently been shown to be more frequent among male Hispanic immigrants (Caetano 1987; Vega, Kolody, Aguilar-Gaxiola, Alderete, Catalano, & Caraveo-Anduaga, 1998). Thus, even though the rates of depression among Hispanic immigrants may initially be lower than native-born whites, the fact that they have a higher incidence of substance abuse may offset this gain over time (Vega, Sribney & Achara-Abrahams, 2003). The effect of drugs and alcohol were succinctly described by one man in the following way:

[GROUP 2]

P7: I believe that every person has depression for different reasons. For some it is drinking too much alcohol, sometimes it is also the stopping of drinking that brings on depression... in some cases it can be the same because of using some drugs, like marijuana or cocaine.

Remedies for depression

There were four proposed remedies to depression, all of which related very closely to previously described symptoms and causes. Although it was not a very common solution at least two groups suggested drinking and taking drugs as a way to reduce depressive symptoms. Although contested by other group members, this was seen as a reasonable way to prevent the onset of depression. The ambivalence surrounding this remedy is evidenced by the exchange from one of the groups below:

[GROUP 7]

P2: Many begin a vice because of it [depression]

P1: Yes, they want to forget about it [depression]

P4: They want to forget, and they think that drinking alcohol or smoking drugs and all that, will help them feel better.

Moderator: And what do you think of this recourse?

P3: It's negative.

P1: Well, it can help you to forget for a while, but after it comes back worse. It's temporary.

The groups also noted that it was an acceptable solution to seek professional help, but they rejected the notion that this included medication. They specifically focused on the usefulness of psychotherapy, not medication. In fact, their conversation around depression was sprinkled with anti-medication discourse aimed specifically at what they saw as a purely U.S. phenomenon. This finding suggests a potential willingness among Mexican immigrant men to use psychotherapy services if presented as simply “help from a professional,” especially without

any pressure to take medication. One participant argues for the benefit of psychotherapy without medication by saying:

[GROUP 3]

P3: If it is depression, I think that the best help is at a professional level. I think that psychological counseling is the most important medication. A while back you [the moderator] asked a question about how we thought of the Americans' approach to depression; I say that the Americans have a lot of depression, too much depression. Unfortunately, they all want to solve it with pills.

Emphasis was also put on how the community and friends could help free someone from depression. Given the many examples the groups provided of friends and family talking to the person or inviting them out for fun, it can best be summarized as curing depression by increased socializing. In a more colorful excerpt it was even described as an “attack on depression”:

[GROUP 4]

P4: I would say that, well, in the eight years I have lived here in the United States, the way to attack stress, in order to attack depression, is to force socializing with other people...I would say that the best medicine is socializing and to work in a group because you can forget certain things [worries] and focus on other things when you are with a group.

The fourth and final suggested remedy that participants discussed was family reunification. Migration researchers typically think of this reunification as occurring when the depressed migrant moves back to his home country, also known as the “salmon effect” (Norman, Boyle, & Rees, 2005). This was not, however, what the participants seemed to have in mind. In the groups where the participants talked about this as a remedy for depression, they did so from the perspective of bringing their families to the U.S., *not* as a return to the country of origin. A good example of the discussion on this issue is the following comment:

[GROUP 2]

P6: I think that, as we've been talking about family, that, if my wife was in Mexico and I was here, I would begin to think, talking with my family, as the other gentleman did, if it was worth it. Money is a necessity, it's true, but being here in the US with my family, would change a lot...because I could see my children, my wife, and all that.

Colloquial terminology

At the end of the focus groups the participants were asked to think of colloquial words that are frequently used to describe *depresión* (depression) or its symptoms. In general, the groups offered two alternative “proper” words for *depresión* (depression) - *aguitado* (depressive attitude, often used in an accusatory way by friends) and *achicopalado* (depressed with an emphasis on lack of energy, claimed to be more often used in the state of Veracruz) – as well as one alternative slang term specifically use to refer to men – *menopausico* (menopausal, often used in a chastising way by friends). An example of the use of these terms from group 2 demonstrates the complexity in the language surrounding depression in this population.

[GROUP 2]

P2: *Aguitado*, that's one.

P1: *Achicopalado*, *me siento achicopalado*, that is another one.

P6: There are many words that are invented, but don't really exist...[but] they are in the vocabulary.

P5: (jokingly says) Why don't you pass me a dictionary?

P2: There are words that are...

P1: Let's say I'm Mexican, we use that word [*aguitado*] when one of us feels like we are not going to do some job. Then we say “You know, I am not going to do that job, *me siento achicopalado*...”

P3: Also, “*esta aguitado el chavo*” (this guy's got a depressive attitude) or “*algo esta aguitado*” (something is depressive [about him])

P6: In Mexico, there are many different forms of words, here [in the U.S.] we run into them all the time. We are always like, “What word did he [another Mexican] say?” Some people pronounce some words strangely, and it makes the words strange....

In group 3, below, the participants had a good laugh when one of them mentioned that men with depression were sometimes referred to as being *menopausico*. The use of this term,

however, also serves as an indicator that the stigmatization associated with male depression is clearly not absent from this cultural group, although it may depend on whether the reasons are seen as legitimate and the age of the person effected.

[GROUP 3]

P4: Sometimes with these types of situations, sometimes, with people that are older, we say *pasando la menopausia*, that's said to men, or if my son said it, it would be, "*estas menopausico*, that's why you are walking around with that attitude."

There were many more alternative terms offered about the symptoms of depression than were offered about the concept of depression. I have listed these terms and their associated descriptions in Table 3. All of the symptoms listed in Table 3 are variations on symptoms already mentioned. Also, most of the terms listed in Table 3 refer to interpersonal problems and depressed affect symptoms, which underscore the importance of these two groups of symptoms in understanding how Mexican immigrant men identify and talk about depression among their friends, co-workers, and compatriots.

("Table 3,")

CONCLUSIONS

The data collected in this project provide a much needed empirical source of information on the meaning and symptoms of depression among Mexican immigrant men. From the discussions surrounding the vignette, depression clearly appears to be a valid and familiar concept. While the reporting of somatic symptoms did occur, it appears that interpersonal problems and depressed affect symptoms are among the most salient in identifying someone as depressed. These include chatting less, not opening up to others, and acting withdrawn. The causes of depression are seen as predominantly social in origin, arising directly out of the

participants' experiences of immigration and adaptation. Most especially, these include experiences with discrimination, long work hours, and social isolation. Similarly, the proposed remedies are also primarily social in nature with an emphasis being put on help from the community, the family, or a professional.

There are some limitations to this research that should be kept in mind. One is that the research was restricted to a small sample of adult, male, Mexican immigrants living in the southeastern US. While this is an important group, it also represents only one small segment of the U.S. immigrant population. Future work needs to incorporate women, other nationalities, and different ages, with specific attention to how the concept of depression may vary across these subgroups.

A second limitation is one that burdens all cross-cultural work, which is the use of culturally constructed terms to elicit information about these same terms. Simply asking about depression constructs a concept that may not have arisen from the discourse itself. By beginning each group with an identical vignette that does not mention the word depression the strategy was to observe whether or not this concept was raised first by the groups or whether it had to be raised by the moderator.

The data also do not allow for a discussion of how depression may be differently conceptualized in the US versus Mexico because the entire sample is of immigrants. Having lived in the US for a number of years and been exposed to advertising and, in some cases, to mental health outreach, asking this sample to recall impressions about depression prior to immigrating may be difficult. They have a uniquely immigrant view of the concept of depression. It would be a fruitful future endeavor to conduct comparison studies of depression among Mexican men in Mexico who have not previously migrated to the US.

There are two suggestive findings that have not been previously discussed, but which hold implications for future work. One is that the symptom categories traditionally applied in depression research may not be mutually exclusive in the case of Mexican immigrant men. This research suggests that two of the terms used to refer to depression symptoms would likely be categorized as both somatic and depressed/positive affect symptoms – *está cabizbajo* (sad and lacking energy) and *está desganado* (lacking interest and energy). These symptoms suggest that the category of somatic symptoms may be intertwined with other categories of symptoms in a Mexican immigrant conception of depression. This could explain the finding of a combined somatic/depressed affect factor of depression found by Guarnaccia et al. (1989) on the CES-D.

The second suggestive finding is that there are some symptoms that arose in these focus groups which bear a striking resemblance to symptoms of *nervios* (nerves) and therefore may imply shared cognitive behavioral processes among Mexican immigrant men. In their research, Salgado de Snyder, Diaz-Perez & Ojeda (2000) note four symptoms generally related to *nervios* as *idea pegada a la mente* (an idea stuck to one's mind), *distruido o ausente* (distracted or absent minded), *triste, decaído, o agitado* (feeling sad or down), and *irritable o enojón* (irritable or angry). In this study, the three symptoms *triste/tristeza* (sad/sadness), *se preocupa siempre* (constant worry), and *anda pensando* (always thinking) could easily be paired with the *nervios* (nerves) symptoms.

Some important clinical implications can be drawn from the causes and remedies the participants noted. One might be for clinicians to work with clients to create a balance between work and relaxation. This was seen as a major social cause of depression and providing guidance on how to better manage this balance may aid in recovery and prevention. Similarly, it is important to be aware of the unique troubles of family separation and social isolation that

immigrants face in the US. At the same time, recognizing that low wages often force immigrants to work long hours and live with a large number of strangers to cover costs of living. Given the emphasis put on increased socialization as a remedy for depression, clinicians may consider helping the client to form ties to local civic organizations where he may meet new friends.

Future qualitative studies examining illness perceptions and healing behaviors are going to be essential components to providing culturally competent care to a diverse clientele. Care must also be taken to recognize the importance of context when generalizing findings about Latinos. Aside from profound country of origin differences, immigrant Latinos and native-born Latinos also differ in many other ways that have implications for mental health treatment.

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TABLES

Table 1: Focus group demographic information

	Focus Group ID	Number of Participants	Mean Age	Mean Education	Mean Years in US	Mean Acculturation Score ^a
Mexican	GROUP 1	5	42	9	13	1.4
	GROUP 2	7	41	8	6	1
	GROUP 3	6	38	9	11	2
	GROUP 4	4	30	12	8	1.9
	GROUP 5	7	28	12	2	1.1
	GROUP 6	5	28	9	10	1.2
	GROUP 7	4	25	10	1	1.6

^aA score less than 2.99 reflects low acculturation (Marin & Marin, 1991)

Table 2: Colloquial Symptoms of depression and English translations

Spanish Word	English Translation	DSM-IV Symptom
<i>Todo lo bueno lo ve malo</i>	Everything good seems bad	Lack of pleasure
<i>Está viviendo por vivir porque ya no le interesa nada</i>	Just living to live because nothing is interesting	Lack of interest
<i>andaba retraída</i>	Feeling withdrawn	
<i>ya no platica/no habla como antes</i>	Not chatting/ Talking less	
<i>quiere abrirse</i>	Not "opening up" to others	
<i>falta hambre/falta apetito</i>	Lack of hunger/ lack of appetite	Changes in appetite, weight, or sleep
<i>falta de dormir</i>	Lack of sleep	Changes in appetite, weight, or sleep
<i>reduce el estado ánimo/sin ganas de hacer nada</i>	Reduced energy/lack of energy to do anything	Decreased energy
<i>dolores del estomago</i>	Stomach aches	
<i>dolores de la cabeza</i>	Headaches	
<i>la sangre es la que está mal y viene la alarma al cerebro</i>	It is the blood that's bad, it sends an alarm to the brain	
<i>triste/tristeza</i>	Sad/sadness	Depressed mood
<i>se preocupa siempre</i>	Constant worrying	
<i>anda pensando/sigues pensando</i>	Always thinking / thinking too much	Difficulty thinking, concentrating, or making decisions

Table 3: Colloquial Symptom Terminology and Descriptions

Spanish Word	Description
<i>aguitado</i>	Depressive attitude, often used in an accusatory way by friends
<i>achicopalado</i>	Depressed with an emphasis on lack of energy
<i>menopausico</i>	Menopausal, only used to refer to depressed men, often chastisingly
<i>está cabizbajo</i>	Being sad and lacking energy.
<i>está exhausto</i>	Being "stressed out," "done in," or exhausted.
<i>está aburrido</i>	Bored and not interested in anything.
<i>anda sacado de onda</i>	Distracted by thoughts/confused & troubled (Used mainly by youths.)
<i>está en las nubes</i>	Lost in thought or distracted. "Head in the Clouds".
<i>está desganado</i>	Lacking interest and energy to do anything.
<i>ando de la fregada (o de la chingada)</i>	Worrying and feeling desperate. "Boxed in"
<i>está distraído</i>	Distracted by thoughts.
<i>está amargado</i>	Being closed off from others, embittered and always bothered by things