Depression in Latinas Residing in Emerging Latino Immigrant Communities in the United States

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Abstract:

This study examined the ways in which depression affects immigrant Latina women residing in an emerging Latino immigrant community in the United States. Three Spanish-language focus groups were conducted within a community-based participatory research framework. Latina women expressed concerns about their immigration status, separation from family in their native countries, and about finances and inabilities to meet family obligations. They expressed fears for their children in the United States. Their sociopolitical, economic, and familial explanations for depression differ from the individual, biological explanations of depression common today. Implications for policymakers, community organizers, health care providers, public health educators, and school counselors are presented.

Este estudio examinó las formas en las que la depresión afecta a mujeres inmigrantes Latinas, que residen en una comunidad de Latinos emergente en los EEUU. Tres grupos focoles en español fueron realizados utilizando el modelo conceptual de investigación comunitaria participativa. Las mujeres Latinas en este estudio expresaron preocupacion por sus estatus de inmigración, la separación de sus familias en sus países, las finanzas, el no poder cumplir con sus obligaciones familiares, y el terror por sus hijos en los EEUU. Sus explicaciones sobre depresión en las areas sociopolíticas, económicas y familiares difieren de las explicaciones individuales y biológicas comunes hoy en día. Las implicancias para quienes diseñan políticas, organizan la comunidad, proveen asistencia médica, proveen educación en salud publica, y son consejeros de escuela son presentados.
Keywords: depression; Latina; Latino; Hispanic; community-based participatory research

Article:

Latinos in the United States experience more depression than Whites and African Americans, with Latinas in particular reporting poorer mental health and less experience with mental health services than their White and African American counterparts (U.S. Department of Health and Human Services, 2007). Latinos comprise 15.1% of the U.S. population (U.S. Census Bureau, 2008), and by 2055, they may account for 25% of the population (U.S. Census Bureau, 2004). Although the largest portion of the U.S. Latino population is clustered in traditional gateway Latino cities (Dallas, Los Angeles, Miami, and New York), the fastest and most sustained growth is occurring in nongateway states in what are deemed emerging Latino immigrant communities (Wainer, 2004).

One of these nongateway states, North Carolina, has the fastest-growing Latino population in the country (North Carolina Institute of Medicine, 2003; U.S. Census Bureau, 2005a). In 2005, Latinos made up 6.3% of the state's population, and in Guilford County, where the study reported here was conducted, Latinos accounted for 5.4% of the population (U.S. Census Bureau, 2005a). Immigrant Latino residents have noted that their new communities lack similarities to their country of origin, bilingual service providers, and culturally relevant

services and resources, including ingredients for making Latino meals, Spanish-language religious services, and translated materials from local schools and social service providers (Villalba, Brunelli, Lewis, & Wachter, 2007; Wainer, 2004). These perceived deficits may contribute to declines in mental health, yet little is known about the mental health of residents in these emerging communities.

FACTORS CONTRIBUTING TO DEPRESSION AND DEPRESSIVE SYMPTOMS IN LATINAS

Most of the research on depression has focused on individual explanations for depression (e.g., biological and psychological etiologies). However, additional explanations may exist. Immigrant Latinas living in the United States may experience depression because of social and contextual problems such as difficulties with acculturation, discrimination based on ethnicity or presumed immigration status, and poverty. These conditions are complicated by language and cultural barriers to seeking and receiving mental health services (Azocar, Miranda, & Valdes Dwyer, 1996; Organista, 2007; Santiago-Rivera, Arredondo, Gallardo-Cooper, 2002; Stacciarini, O'Keeffe, & Mathews, 2007). Acculturation, or the process of having one's native culture influenced by the dominant culture, often comes with a certain level of conflict and stress that may be manifested as depression and depressive symptoms (Heilemann, Lee, & Kury, 2002; Sue & Sue, 2003; Wilkinson et al., 2006). The stress of adjusting to new customs, laws, social mores, and language, and the perceived sacrifice of one's native culture, have been correlated with both anxiety and depression (Crockett et al., 2007).

Finch, Kolody, and Vega (2000) reported that acculturative stress and perceived discrimination were linked to depression in Latinas born in Mexico and currently living in the United States. Experiences with discrimination can cause anger, anxiety, and even posttraumatic stress disorder (Bryant-Davis & Ocampo, 2005). To complicate matters for Latinos in the United States, the ongoing immigration debate in local, state, and national discourse has contributed to an increase in discrimination against Latinos. The Southern Poverty Law Center (2008) reported a 40% increase in the number of hate groups in the United States between 2000 and 2005, and attributed most of this increase to anti-immigration sentiment. This parallels a 25% increase in the number of hate crimes against Latinos between 2004 and 2006 (U.S. Federal Bureau of Investigation, n.d.).

Latinas born in Latin American countries have generally been socialized to adhere to certain gender roles and expectations. For example, many Latinas adhere to the concept of *marianismo,* meaning that women are expected to demonstrate that they are good mothers and supportive spouses by putting their families' needs ahead of their own and sacrificing their own well-being for their loved ones (Santiago-Rivera et al., 2002). Although *marianismo* may not appear to be a positive, beneficial, or redeeming perspective to non-Latinas, for Latinas it is important to aspire to this ideal. Without opportunities to demonstrate these cultural values and principles, some Latina women feel as though they are unfit mothers, which can contribute to mental and psychosomatic physical illness (Mann & Garcia, 2005; Mendelson, 2002). McNaughton, Cowell, Gross, Fogg, and Ailey (2004) found that depression among Mexican women was associated with unmet familial responsibilities like those mandated by *marianismo.*

The link between poverty and depression and depressive symptoms is well established (Goosby, 2007). Because Latinos are twice as likely as Whites to live below the federal poverty line (U.S. Census Bureau, 2005b), they can be expected to experience more depression. Heilemann et al. (2002), who studied factors associated with depression in Mexican and Mexican American women in California, found that one of the strongest relationships was between depressive symptoms and women's inability to meet the material needs of their families. Because of the strong correlation between income level and educational attainment, Mexican and Mexican Americans are at a disadvantage for successfully rising out of poverty because they are the least likely of the largest U.S. demographic groups to complete a college degree (Harris, Edlund, & Larson, 2005; Pew Hispanic Center, 2005a). Aranda, Castaneda, Lee, and Sobel (2001) found that low educational attainment was a strong predictor of depressive symptoms.

Although Latinas report higher levels of depression than White or African American women and are more likely to be exposed to factors that increase their depressive symptoms, they are less likely to use mental health

services (Harman, Edlund, & Fortney, 2004). Several barriers are associated with low utilization of mental health services by Latinas coping with depression, including limited numbers of Spanish-speaking bilingual service providers and lack of insurance (Vega & Alegrfa, 2001), shame associated with mental health and psychiatric diagnoses (Heilemann, Coffey-Love, & Frutos, 2004), preference for speaking with friends and religious leaders (Heilemann & Copeland, 2005), and a general lack of trust in and understanding of the U.S. mental health system (Santiago-Rivera et al., 2002). Latina women typically cope with depression first through various personal efforts, for example through spirituality and by keeping busy (Mann & Garcia, 2005; Mendelson, 2002).

COMMUNITY—BASED PARTICIPATORY RESEARCH

Findings from studies focused on women living in established U.S. Latino communities may not be applicable to samples in emerging Latino immigrant communities (Pew Hispanic Center, 2005b; Phillips & McLeroy, 2004; Villalba, 2007; Wainer, 2004). Community-based participatory research (CBPR) is a way to access phenomena in these emerging immigrant communities. With its roots in constructivism, empowerment, and critical theory, CBPR is "an orientation to research" (Minkler & Wallerstein, 2003, p. 4) in which academic researchers and community members are coresearchers (Jones & Wells, 2007).

Israel, Shultz, Parker, and Becker (1998, p. 177) have defined CBPR as:

> A collaborative approach to research that equitably involves, for example, community members, organizational representatives, and researchers in all aspects of the research process. The partners contribute "unique strengths and shared responsibilities" to enhance understanding of a given phenomenon and the social and cultural dynamics of the community.

The Guilford County Community Coalition for Latino Mental Health is an interdisciplinary, collaborative CBPR team initiated in 2006 by the first author to study racial and ethnic disparities in mental health care in Greensboro, North Carolina, an emerging Latino community. The team is composed of a Latina lay health advisor, a health advocate and family member of a recipient of mental health services, a case manager for Latina mothers with young children, a Latino mental health awareness campaign director, an administrator for a child development center, two mental health counselors, two public health educators, and an undergraduate and a graduate student. Many community team members are bicultural and bilingual (Spanish and English). Community members represent the following community-based organizations: Mental Health Association in Greensboro, North Carolina; Head Start, Family Solutions (private provider of mental health services), the Guilford Center (community mental health center), La Vela Latino Center for Spiritual Care, and the university-affiliated Center for New North Carolinians, Center for Youth, Family, and Community Partnerships, and Center for the Health of Vulnerable Populations. The team is led by two academic researchers from two disciplines (one of whom is bilingual and bicultural). In a previous study, this team examined individual, organizational, and community-level factors affecting access, use, and perception of mental health services for the Latino population in Greensboro (Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008). Based on the findings from this first study and the interest of community members, the CBPR team identified depression in immigrant Latina women as an issue of concern. The Latina population in the United States is increasing, depression in immigrant Latinas is prevalent, and little is known about depression in these women, especially those residing in emerging Latino immigrant communities. Therefore, the study featured here explored how immigrant Latinas living in emerging Latino communities describe, cope, and treat their depression and depressive symptoms.

METHODS

We conducted three Spanish-language focus groups with adult immigrant Latina women. Community team members, led by the academic researchers, designed the recruitment strategy, demographics questionnaire, and focus group interview guide. The academic researchers provided education and training in research methods, including focus group methods and informed consent procedures. The community team members then facili-

tated the focus groups, provided child care during focus groups, and assisted with data analysis and dissemination of the findings.

Sample

Participants with similar life experiences were targeted for our three focus groups (Barbour & Kitzinger, 1999; Morgan & Scannell, 1998). Thus, our sampling strategy sought participants who were immigrant Latinas (Latina women who were not born in the United States), aged 19 or older, and interested in talking about how depression affects immigrant Latinas residing in an emerging Latino community in the United States. Flyers advertising the study were distributed by community research team members through child care centers and community programs for immigrant Latina women and their young children. The Institutional Review Board from the university where the two academic researchers are employed approved the study. The bilingual and bicultural focus group facilitators reviewed the study and Spanish language consent forms with potential participants. All participants signed a consent form, and were given a copy of the form. The convenience sample included 30 participants between 22 and 41 years of age (M = 32). Nine women participated in the first focus group, 11 in the second group, and 10 in the third group. Twenty-eight of the women were from Mexico; one was from El Salvador and the other from Venezuela. The length of their residence in the United States ranged between 2 to 18 years (M = 8.2). All had between one and seven (M = 2.6) children who were between 3 months and 20 years of age (M = 6.9 years). Immigration documentation status was not collected, but focus group discussions suggested that the majority of participants were undocumented; that is, they were citizens of other countries and did not have the requisite U.S. government documentation (a green card or student visa) to reside in the United States legally.

Spanish was the participants' primary language. Thirteen (43.4%) rated their English proficiency as "beginning or little," seven (23.3%) rated their proficiency as "some conversation," four (13.3%) rated their proficiency as "intermediate," and two participants (6.7%) rated their proficiency as "high." Four women (13.3%) did not answer the question.

Data Collection

Focus group participants answered open-ended questions from a semistructured guide, following Morgan's (1997) recommendations. Data were collected in May 2007. Because Spanish was the first language for all participants, the focus groups were conducted in Spanish.

Four Spanish-speaking community team members, two of whom were Latinas and all of whom had experience in facilitating groups of Latina women, conducted the focus groups. They were divided into two teams of two, and the first team conducted one focus group, and the second team conducted two. In addition to the facilitator dyads, at least one equipment technician (another member of the CBPR team) was present at each focus group meeting. The facilitators and equipment technicians were all women. Before the start of each group, demographic data were collected using a 9-item self-report questionnaire, and participants were told to maintain the confidentiality of group discussions and group members by refraining from sharing information discussed during the group.

Focus groups were held in a Head Start child development center, a local church, and a public library, selected for proximity to participants' homes and places of employment, as well as participants' familiarity and comfort with the settings. Transportation was provided for two of the three focus groups. (Transportation was not needed for the third group because of the location and timing of the session.) Child care was provided for participants' young children during all focus groups. Each session started with informal conversations among participants and focus group facilitators. Before the facilitators started asking questions from the interview guide, they informed participants of the free-flowing nature of the conversation and encouraged them to expand on their responses. During the sessions, facilitators asked follow-up questions to further explore the responses and obtain data on particular topics and experiences. Field notes were taken by the facilitators. Focus groups were audio recorded with digital audio recording equipment; the first focus group lasted 1 hour 6 minutes, the second, 1 hour and 48 minutes, and the third, 1 hour and 51 minutes. Participants were given a $25 gift card.

The Spanish-language audio recordings were translated into English-language audio recordings by a bilingual translator. These Spanish-to-English digital audio-recorded translations, which were also in Waveform audio format, were verified by a bilingual and bicultural research team member and found to be accurate. A second verification of the Spanish-to-English translation was made by a bilingual research team member who also found it to be accurate. The English-language digital audio recordings were then transcribed into English text by a professional transcriptionist. These transcripts were used in the data analysis, because some team members did not speak Spanish. The bilingual and bicultural focus group facilitators participated in the data analysis to reduce the potential for cross-cultural interpretation errors (Esposito, 2001).

Data Analysis

Data were analyzed using the content analysis method described by Patton (1990), following the tenets of qualitative description described by Sandelowski (2000) and by Sullivan-Bolyai, Bova, and Harper (2005). First, the authors immersed themselves in the data by reading and rereading the transcripts. Notes were made in the margins of the texts on the causes of depression, the ways depression was expressed, and the women's views and experiences with seeking help for depression. The researchers then categorized the data using concepts that came from participants' words. These categories were reviewed for internal homogeneity and external heterogeneity and then tested for completeness.

FINDINGS

Causes of Depression

The most common causes of depression noted by participants were concerns about immigration status, separation from family in their native country, fears for children in the United States, worries about finances, the consequences of not being able to meet family obligations, and loneliness.

Immigration to the United States was one of the most often cited reasons for worry, sadness, and depression among Latinas. Many women said they had never experienced depression in their native country. Even though the women's length of time in the United States varied greatly, they shared similar feelings about leaving their native country. One participant commented on how she felt when she came to the United States:

> When I first came to the United States, it was about a year that I had this sadness. I don't know if it was because my parents were at home, but I was very sad and had a lot of desire to cry.

After she made this comment, all of the other group members said that they had felt the same when they arrived in the United States.

The women reported that lack of documentation caused a lot of stress and worry; many of these Latinas were extremely fearful of deportation. Some women were worried that non-Latino members of their community would find out their status and report them to the authorities. Women feared that if they were deported, their children who had been born in the United States would have to be left with a relative or would be taken by the government. These feelings also were compounded by mothers' inability to fulfill their family obligations due to being separated from their children. One mother expressed her fear this way:

> I had a friend, who was deported, and she came back and they re-deported her again; and she had to leave her children, and they were taken from her, and for me to see that, see children taken away, oh, I say, no. I don't want this to happen to me. So, I live with this fear.

Separation from family members living in their native country was another reason for worry and sadness. Almost all of the women indicated that some family members, including elderly parents, siblings, and children, were still in their native country. Many of the women became emotional when they spoke of how they missed their families. One woman, who wept as she spoke, explained how the absence of her family had affected her, saying,

> I still really miss my family, my parents, those that are in Mexico. I have this emptiness inside me even though I don't recognize it. Sometimes you can hide in this country at work or in going out to the store or going out to some other place. You can hide, but always this familial circle around you is missing. The unity of the family where you have the support. Where we, ourselves, can feel accepted.

The women also worried about the physical and mental well-being of family members at home and were concerned that they were not there to care for them. Some became very emotional when they talked about ill family members and deaths that had occurred while they were in the United States. One woman expressed grief and guilt for not being there when her mother died: "It affects me because I couldn't go when my mother died, because I didn't have my residency papers then, and now I have the papers but I don't have the money." This same woman also told the group how depression affected her and her family who still lived in her native country. She said, "It's been a few years since . . . one of my brothers killed himself because of depression . . . and I have another two brothers who also have depression in Mexico. This affects me a lot." Another woman spoke of her sick mother, who still lived in her native country, saying,

> My mom says she wants to come and to (meet) the kids, and she's not well, and ... she's getting worse, and I don't know if one day I (will be living) here (in the United States) and my mom is going to pass away. God, I hope not, but I don't know.

In one focus group a woman described how she coped with not having her family with her, saying: "But we help them economically. If we were there, we couldn't help them the way we help here, but you miss being there with them to be able to see them." She said she was often jealous of her siblings who still lived with her parents, but they were unable to provide financially for the family, so she believed she was making a contribution to her family by being in the United States. Thus this participant mitigated her feelings of loss and separation by realizing that she played a pivotal role for her family in Mexico by staying in the United States. Separation from children also contributed to depression. One woman spoke of her daughters who were still in Mexico. She said she missed them and felt torn leaving them in her native country. Tears turned to sobs when she said:

> I have two daughters in Mexico, and I don't see them. I ask others to take care of them. One of them is 17 and the other one 15. I feel awful because I have my children here, too, and they're going to know the difference. I'm with the ones here and I'm not with the ones in Mexico. I'm teaching my children, the ones here in the United States, about my children in Mexico. I send movies and pictures to teach them of their other brothers and sisters, but it's really sad when your older children aren't with you.

The other women in the group sympathized with her despair; they comforted her and agreed that it was hard when they immigrated to the United States to leave family behind, especially their children.

Fears for their children in the United States were another major reason for depression. These women repeatedly expressed concerns about school safety, high dropout rates, and children losing their sense of culture. The women said they worried all the time for their children. Many believed that their children were undeservedly bullied and subjected to violence and racism because they were Latino. Some said their children talked about other children bringing weapons to school. One mother disclosed that boys of different races had raped her daughter while they were supposed to be in school. She tearfully recalled: "They didn't find her until the next day at 3 in the afternoon. The police found her and this is the pain that I have." Sobbing when she finished the story, she said:

> I took her to the doctor and she had been raped . . . You send your kids to school, and you don't know what is going to happen to them ... I thought that someone had killed my daughter and I had no idea what was happening.

Many of the women in her group comforted this woman and said that they were glad her daughter was not killed; they also expressed fear and anxiety because they did not know what would happen to their children while they were at school.

The women attributed the high dropout rates of Latino children to the poor outlook for college attendance because of documentation status and the need for children to begin working in order to help support the family. One woman, noting that Latino children dropped out of high school because of the hopelessness of future academic success, said: "It complicates your life to not have legal status. Our children might leave school because they aren't going to be able to go to college if their parents can't produce documents." Another reason for the high dropout rate was the need for children to contribute financially to the family. One woman explained this by saying:

> There are economic problems and they understand it, it affects them; and then people ask, "why do young kids stop going to school and start working so young?" and I don't know. They prefer to see for themselves and there is pressure from home. That's why they leave school, and the parents can try to make them go to school, but there comes a point when they lose this ability, either for economic reasons or whatever, and the children leave school at a really young age.

Women worried also about their children abandoning their culture because of the immense pressure to fit in at school. These mothers said that although they encouraged their children to maintain their cultural traditions, they feared they would not, because the children were bilingual. One mother expressed her concern this way: "It's that the children are bilingual: they speak English so that they can function in this country, but also it's important that they're aware of their roots and hang on to their culture."

All of the women said that children had anxiety and stress like adults; however, they feared that in part it was their own stress and the stresses in the home that caused anxiety in their children. For example, many of the women worried that their children would adopt negative behaviors they witnessed at home, such as a husband's aggressive behavior toward his wife, react to stress in a helpless fashion, have to work several low-paying jobs to support a family, or not be able to learn enough English to succeed academically.

Concerns about finances were a major factor in these women's depression. Many were not only responsible for caring for themselves and their immediate family members in the United States but also were obligated to care for those in their native country. These financial responsibilities meant that few women were able to afford physical and mental health care. One woman spoke about the medical costs when she had an infection:

> When I was coming to the United States we went through the desert, and I had to drink dirty water, and I got an infection, a urinary infection, and I went to the hospital and I had no idea how expensive it was going to be. They charged me $1,600. I don't have that kind of money. I don't make enough money to pay that. My spouse has been three months without any kind of steady work, and I have three children that I need to feed. I have to pay rent and bills, too. I don't have the money to pay the bills, the medical bills.

The women in every group expressed concerns about money. One woman said that the fact that her husband was unemployed made life very stressful for them. She observed: "I worry the most because my husband does not have a job, and we don't have enough money for the bills, for food." Another woman expressed similar anxiety when she was asked for money at a church. She said: "I went to this church, and then they asked for the offering, and I'm poor. I don't even have enough money for gas and they're asking me for an offering." Still another woman talked about economic problems as something very hard to overcome. As she explained,

> A lot of times when women become really, really depressed it's an economic thing. I have a friend whose husband beats her up. She doesn't have any money. She doesn't have money even to eat. She takes care of her kids . . . She doesn't even have the motivation to clean her house and she doesn't feel

> life, and she's tried to seek mental health help, but they charge so much. So, she hasn't gotten help. So, this has a lot to do with it. She can't afford it.

Most of the women had come with their families to the United States in order to make a better life for themselves and their children economically, but finding work and providing for their family in the United States were not as easy as they had expected.

The challenge of meeting family obligations was another cause of depression for these Latinas. They believed that if they were not able to perform all of the duties that traditional Latinas were expected to do, such as maintaining the home and raising the children, they were not meeting their expectations as a wife and mother. One mother described her typical day as follows:

> Here in this country, why do they bring us? It wasn't to live in luxury. It was to cook and clean and sew. They brought us to help them, and imagine that they've been at work all day and they come home and the house is not clean or dinner isn't cooked. My husband would say, there are 24 hours in the day—how long does it take to clean the house or cook?

Other women said that although they had modern conveniences in the United States such as electric appliances, which made some domestic chores more manageable, they were often so busy with their kids and other responsibilities that it was hard to do all that was expected of them before their husbands came home from work. Many women said they lacked the energy to perform some of the tasks and attributed this to depression. In every group, the women noted that being depressed or sad was directly correlated with not having the energy or motivation to clean the house. One woman described it this way: "I get really tired and I don't feel like cooking or cleaning or doing anything."

The women all agreed that because they did not work outside the home, they had to keep the house clean. One of the women expressed her feelings about this: "If we don't work outside of the home, it is our job to do—to take care of the home."

Expressions of Depression

Symptoms of depression mentioned in each group included stomach problems, lack of energy or motivation to perform household duties, mood swings, and sleep disturbances. Stomach problems included diarrhea, constipation, nervous colitis, and ulcers. In each focus group, women described how stomach (gastrointestinal) problems occurred when they had problems with their stress or nerves, reflecting their view that mental or psychological issues affected the physical body. When one of the facilitators asked the group to talk about how mental health issues could affect them, one woman said: "Whatever is mental is physical as well, because stress, which is a sickness, a mental sickness, will affect your body. Stress can lead to health problems." Another said that depression can cause "some sort of physical problem, like stomach problems, constipation, diarrhea, when they feel or they have problems." They also talked about how problems with nerves or stress could affect appetite. Women said that this problem could go either way: someone could eat too much or not at all because of depression. Some of the women described how mental health and physical health were related. The women agreed that mental health was important and it affected every aspect of life.

The women considered not maintaining the home an indication of depression. Because taking care of the house, cooking meals, and caring for children are traditional norms for Latinas, when these duties were not fulfilled, the women believed that they were letting everyone down, including themselves. Women identified friends or family members as depressed when they noticed a change in their behavior in the home. As one woman observed about a woman who did not clean her home:

> She feels really sad all the time. She doesn't eat and she just wants to sleep and sleep. Sleeping is her nourishment, and she's also neglected to take care of her children as well and neglected to take care of her home.

Negative coping mechanisms such as consuming alcohol, smoking, and using illegal drugs in stressful situations were often referred to as "vices." Although the women thought that in the long run these strategies were not beneficial, they noted that Latinos often succumbed to them. One woman said of her brother:

> I think my brother has depression because he smokes a lot. He has two packs a day sometimes, and I think he needs help because he smokes and smokes, and also he doesn't seem like he wants to go out.

The women noted that men, in particular, behaved more violently when they used alcohol or drugs, and this in turn affected the family. One woman shared a story about her brother and his family:

> My brother—I have a brother and he's sometimes not good. He has a job. He works, but sometimes he just goes out with other people from work, with other men, and doesn't come home to his family, and he abandons his family, and he has two girls, and sometimes his—one of his girls will talk to me and say, "Where's my dad?" And this makes me depressed because she really wants her father to be there with her, with them. She wants his love, his affection, and instead of giving that love to his family he gives it to his friends, and I told him, "Look at your children. Look at how lonely they are and enjoy them while they're young. Don't leave them alone." And he just got mad, and that really hurt me.

The women also believed that problems in sleeping were a sign of depression. They said that when people were sad or worried, they slept too much or did not sleep at all and both produced the same result—unproductive workdays. Some women reported being overly emotional when sad or anxious. One woman expressed it this way:

> I had a friend with this problem; depression . . . she didn't have any desire to do anything . . . and wouldn't have any energy to do anything. She wouldn't sleep at night. She cried over anything, and she had an older daughter, and they said that she didn't take care of her or her husband. It was pretty major.

Many women said that they felt alone in the United States. They felt they did not have a social group as they had in their native country. Responses such as this one were common:

> I think it's real easy to get depressed here, because there I had a lot of friends, it was really easy to go out; and, yes, sometimes there wasn't money . . . but it was happier, it was prettier, better, and here you miss your mother, your brothers, if you don't have them here; and for that reason I think it's really easy [to get depressed here].

One single mother discussed the difficulties of rearing a child by herself and the sadness she felt that her child would never know her father. Another woman in that group mentioned that although she was married, she often felt as though she were a single parent because her husband did not emotionally support her or complement her efforts to raise the children. According to this woman:

> Sometimes those of us who do have a spouse, unfortunately, we feel the same way that you do (referring to a single mother). You have to give them (the children)—instill in them the values that you want them to have and raise them because the husband is working all day. You feel really alone.

Other women complained of social rejection and talked about how hard it was to try to fit into American culture while maintaining their cultural roots.

Experiences in Seeking Help for Depression

Because most of the women knew other women who had experienced sadness or depression or had experienced it themselves, many described experiences with mental health care. All of the women said that untreated mental health problems grew worse over time. They agreed that it was important to get help for problems with anxiety

or stress. Some of the women went so far as to say that not getting help could lead to suicide. Yet although the women agreed on the importance of receiving help, they cited numerous barriers to obtaining services, including providers who did not speak Spanish, mistrust of interpreters, fear of disclosing mental health issues due to a perceived lack of confidentiality, and lack of efficacy of prescribed treatments.

Preferences for type of mental health care provider varied. Although women said that they found it helpful to talk to friends about problems, sadness, and anxiety, they did not believe they could get adequate help from them. Most preferred to seek help from professionals, noting that only professionals could provide the care necessary to overcome or improve mental illness. Many also talked about the importance of going to a professional to obtain prescriptions if medications were necessary.

Women were more uncomfortable speaking with two people about their issues rather than just one. Many said it was hard to talk about mental health issues through an interpreter. One woman said: "It's more difficult to tell your secrets to two people . . . it's not just about the language, it's about having the other person there if you're crying."

Women also expressed a lack of trust in interpreters. A group facilitator described the code of ethics for medical interpreters. One woman almost immediately said:

> Well, maybe if you're a professional, but I know some people who, you know, they charge maybe $30 an hour to interpret, but they go ahead and take everything that they hear and tell other people about it.

The women concluded that interpreters needed to be trained and should be required to interpret accurately and keep all information confidential. All women preferred a Spanish-speaking professional to help them with their mental health needs. It was apparent from this discussion that some women had had negative experiences (or had heard of negative experiences) with interpreters when the best interests of the client were not the focus of the interpreter. This also points to the complexities of translating services—simply translating documents and conversations into Spanish is not enough for many Latinas experiencing depression; rather, advocacy on behalf of clients may be expected of translators, making sure to not just translate words but also contexts, and to convey the client's struggles.

One woman questioned the efficacy of medication and the treatment recommended by a health care professional, and others echoed her sentiments. She said:

> I've got really bad nerves and I went to the doctor. They gave me medicine, and they gave me medicine for people who are drug addicted. So I felt even worse than what I felt before. I took the medicine, and didn't sleep at all that night. I was really afraid to be alone, and so I have been afraid to take the medicine, assuming the same thing will happen again; and so I have refused.

There is no way for certain to determine how this participant came to think that the medication she was being prescribed was intended for drug addicts; however, what may be implied here is that there is a stigma about taking psychotropic medication similar to the stigma of receiving mental health in Latino culture (Santiago-Rivera et al., 2002).

When women were asked about healthy ways of coping with stress, many recommended using distractions (e.g., exercises, spiritual activities, and hobbies) to overcome depression. One woman used knitting to cope with her depression, saying: "I was able to control myself more and not think as much by taking the yarn and just knitting and knitting. I was able to control it." Many women also said that spirituality was a big part of their lives, and their faith helped them overcome sadness and depression; they recommended engaging in religious activities as a way to deal with depression. For instance, one woman said: "I rely on God because there is nothing more than Him. In the Bible I find support and I'm able to find strength and tranquility and peace, and that gives me strength to move forward." Although none of the women directly stated how they had arrived at their choices for coping with their stress and depression or the type of community-based resources they used for

coping with their mental health concerns, it should be noted that the community they live in has both Catholic and Protestant churches that offer religious services in Spanish as well as outreach to the Latino community. Furthermore, several community advocacy agencies are involved in disseminating health care information to the Latino community, such as public assistance, mental health care, and medical services. Also, there are at least four Spanish radio stations and one Spanish weekly newspaper that advertise and promote social, medical, and mental health programs intended for the Latino community.

DISCUSSION AND IMPLICATIONS

In our study, immigrant Latinas described their understandings of the causes of depression, the way depression is expressed, and their experiences with seeking help for depression. Their descriptions suggest social, educational, and policy recommendations, and advocacy opportunities for improving the well-being of Latinas in emerging immigrant communities.

The women described discrimination, acculturation, limited financial resources, and family conflict as factors leading to depression. Organista, Dwyer, and Azocar (1993) found similar factors. An additional factor in our study was undocumented immigration status. Further, the concept of *marianismo,* defined by Stacciarini et al. (2007, p. 480) as "women are to be self-sacrificing toward their children and tolerate the suffering inflicted by men" also was noted in our study. As in other studies, these women put the needs of their family before their own (Aranda et al., 2001; Mann & Garcia, 2005; Mendelson, 2002), and they were sensitive to family conflict, which was associated with increased depressive symptoms (Grzywacz, Quandt, Arcury, & Marin, 2005; McNaughton et al., 2004).

Participants' experiences with discrimination reflect the national immigration debate and its impact on the local community. As noted by the Southern Poverty Law Center (2008), the number of hate groups in the United States has grown by 48% since 2000, and most of the increase can be attributed to anti-immigrant groups. The Anti-Defamation League (2006) has gone so far as to link the terms "anti-immigration" and "anti-Hispanic," because most of the newly created hate groups targeting immigrants often depict Latinos in their literature. The Pew Hispanic Center's (2007) *2007 National Survey of Latinos* found that between 2002 and 2007, the percentage of surveyed Latinos reporting an experience with racism and discrimination grew from 31% to 41%. This group of Latinos also linked their experiences with discrimination to barriers to employment and to finding and securing housing and being required to reveal their immigration status (Pew Hispanic Center). The effects of these social and economic issues on the well-being of Latinas are evident in the study findings: our participants' perceptions of depression were linked to immigration status, discrimination, and economic status.

Given the study's sociopolitical findings, nurses and other health care professionals should consider how to design and administer interventions that take into account the social realities of living in emerging Latino communities. Furthermore, nurses and other health care professionals must determine what role they will play in orchestrating the type of immigration policy changes that will result in less discrimination and barriers to services for Latinas, regardless of their immigration status (Shattell & Villalba, 2008). Methods for incorporating immigrant-related considerations must be incorporated into prelicensure nursing education. Action on immigration policy on behalf of immigrant Latinas will help the nurses see the importance of addressing client needs on a systemic level, beyond the needs of isolated individual medical treatments or medical diagnoses.

It also is important for health care providers to gauge the effects of sociopolitical and economic factors on the mental well-being of their Latino clients. As this study has shown, service providers working with Latinas in new Latino communities need to ask questions about patients' experiences with discrimination, prejudice, their family, their home life, and their economic status. Health care providers also should pay close attention to how clients' immigration status may be negatively affecting their mental well-being, because these findings show participants' negative reactions to being victims of discrimination due to their undocumented immigration status. Responses to these questions may lead to further questions about depression or depressive symptoms, and it may help the health care provider identify possible behaviors to target as well as short- and long-term

goals for Latina clients with documented and undocumented immigration status. Responses may provide insight into the daunting experiences of immigrants in the community, presenting service providers with opportunities to advocate at local, state, and national levels on behalf of the well-being of immigrants. These responses may also prompt nursing professionals to partner with other service providers, such as hospital-based or community-based counselors and social workers, to secure additional information on mental health and financial assistance options for Latina patients.

The findings from the study of immigrant Latinas living in an emerging Latino immigrant community are consistent with some of the concepts and ideas presented in the literature. For example, focus group participants shared feelings of loneliness that were related to not having a large enough social group, feeling rejected by the community, and having difficulty in maintaining cultural roots. Similar findings were reported by the Pew Hispanic Center (2005c), specifically for Mexican immigrants in Raleigh, North Carolina, who had significantly smaller family networks than Mexican immigrants in established Latino communities in Dallas, Chicago, or Los Angeles.

In another Pew Hispanic Center study (2005a), Latinos who were Spanish dominant and had limited English proficiency were twice as likely as English-dominant or bilingual Latinos to indicate that discrimination was a major problem for them. The sample in the current study—all of whom were Spanish-dominant—also reported experiences with discrimination and racism. Similarly, Wainer (2004) reported high incidences of discrimination for Latinos living in three emerging Latino immigrant communities in Arkansas, Georgia, and North Carolina. Thus, nurses and prelicensed nursing students (as up-and-coming professionals, soon to enter the nursing workforce) need to explore specific and systemic methods for mitigating the impact of local language policies and social expectations on immigrant Latinas. Specifically, those in the nursing profession should document restrictive language policies in medical settings and propose and promote policy changes for making limited-English proficient clients feel heard and welcomed. Lastly, because it takes at least 5 to 7 years for English-language learners (ELL) to become fluent in English (Samway & McKeon, 1999), nurses must be patient and empathic—and demand the same behavior from their colleagues—when working with ELL Latino clients.

Lastly, barriers to mental health, including few bilingual service providers and mistrust of interpreters, were also reported by this sample. Rios-Ellis (2005) noted that these types of barriers present obstacles for most Latinos seeking mental health services. Wainer (2004) also noted the relationship between limited numbers of bilingual/Latino service providers and low levels of Latino parent involvement in their children's educational experiences as well as other public services. Departments, schools, and colleges of nursing throughout the United States (and particularly in communities with a large bilingual or ELL Latino population) must determine how to increase enrollments of bilingual and/or bicultural students and enact procedures to ensure that these students successfully complete their nursing studies and find employment in health care settings where they can serve bilingual/bicultural Latino clients.

Participants in this study expressed concerns about their children adopting negative behaviors witnessed in the home. Some of the women suggested that their depression and stress could cause stress and anxiety in their children. Similarly, McNaughton et al. (2004) found an effect of maternal mental health on children's mental health in Mexican immigrant families. In their study, children reported greater stress when their mothers had high levels of stress and depression. These findings support participants' concerns about their children's mental health and well-being.

Depression clearly has effects on immigrant Latinas' abilities to meet familial obligations and household role expectations. In Latino culture, it is the woman's duty to maintain the household, and when this obligation is not met, the woman is not fulfilling her job as a wife and mother. There is a cyclical pattern to depression: if women are depressed, they may lack motivation to "keep the house," and if they do not fulfill this duty, they are left feeling useless or inadequate. These findings are similar to those described by Mendelson (2002) in a study of health perceptions of Mexican American women. The women in Mendelson's study found that mental stress

could cause physical ailments or illness. Both the present study and Mendelson's study suggest that women of Mexican descent perceive interference with role expectations to be an indicator of an illness.

Separation from family in their native country was one of the main contributors to depression for women in this study. Indeed, separation from parents, siblings, and children was identified as a major source of depression. These findings are consistent with those of Heilemann et al. (2004), who found that physical separation and inability to personally care for loved ones were central issues for women. Similar data were also collected by Miranda, Siddique, Der-Martirosian, and Belin (2005), who concluded that Mexican women who experience separation from their children are at greater risk for depression than women of Mexican descent who have not been separated from their children.

Other studies (Brown, Abe-Kim, & Barrio, 2003; Schmaling & Hernandez, 2005) have shown that depression screening and treatment of Latina women are inadequate and have advocated for more culturally appropriate interventions. Specifically, Schmaling and Hernandez found that primary care service providers in the United States were less likely to diagnose depressive disorders in Mexican Latinos due to poor understanding of these disorders in this population and lack of clear communication between patients and health care providers. Also, Brown et al. (2003) noted that providers need to understand the cultural context of depression and assess somatic symptoms as possible manifestations of depression or other psychological problems. A more culturally sensitive understanding of depression in Latina women may improve mental health screening for this vulnerable and underserved population.

Immigrant Latina women in this study preferred to receive care from Spanish-speaking professionals. Those in a study by Tucker et al. (2003) expressed similar needs. Unfortunately, it is not helpful to know about depression and the wishes of immigrant Latina women if there are no such services available. More must be done to encourage bicultural and bilingual high school and college students to consider careers in health care. In addition to a lack of Spanish-speaking mental health care providers, there needs to be more readily affordable mental health counseling. A public initiative focusing on mental health could provide free or low-cost counseling centers, much the way public health is funded now.

One limitation of our study had to do with recruitment of participants mainly in early childhood education centers offering programs such as Head Start and Thriving at Three (an initiative of the United Way of Greater Greensboro). As a consequence, all of the participants were mothers of young children. Their homogeneity may have contributed to the similarities in their responses, which may not generalize to immigrant Latinas who are not mothers or who have only older children.

Despite this limitation, the study findings suggest that education initiatives for Latinos, to help dispel the notion that mental illness is a disgrace, could be helpful. Collaboration with religious organizations and community advocacy associations can be useful in mitigating the stigma of mental illness in the Latino community (Sue & Sue, 2003). Religion and spirituality are common ways that Latinas use to cope with depression and other manifestations of stress (Miranda, Azocar, Organista, Munoz, & Lieberman, 1996) and should be supported. In addition, prelicensed nursing students, nurses, and other health care providers must make every effort to learn as much as possible about and from their Latina clients and families. Through professional development and education, as well as recognition that the Latina client is herself an expert on her and her family's experiences, nurses will be better prepared to serve Latina patients and influence public and social policies. Genuine and deliberate efforts by members of the health care community can serve as an important gesture of support toward the Latino community by demonstrating that the health care community is cognizant of and willing to address systemic and individual barriers to Latino health.

In addition, public schools may help the Latino community learn more about mental health and wellness. Previous research has shown that school professionals are concerned about health disparities for Latino students (Villalba, 2007). Mental health workers and public health educators can partner with school nurses, school counselors, and English-language teachers to provide mental health information to children and families. These

same professionals are well suited to collect, process, and apply Latino clients' own expertise to help the community-at-large better understand the concerns and strengths of Latino and non-Latino residents alike. Lastly, the results from the current study can inform community-school partnerships about the type of issues they might observe in Latinos, as well as methods for framing intervention objectives and mental health education.

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