

## Factors Contributing to Depression in Latinas of Mexican Origin Residing in the United States: Implications for Nurses

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### **Abstract:**

**BACKGROUND:** Latinas experience more depression and are less likely to receive mental health support than White women or African American women. **OBJECTIVE:** This article synthesizes the research on depression in adult Latinas of Mexican origin residing in the United States. **STUDY DESIGN:** MEDLINE (PubMed), The Cumulative Index of Nursing and Allied Health Literature (CINAHL), and PsycINFO databases for the years 2000 through 2008 were searched using the keywords Latina, Latino, Hispanic, Mexican American, Mexican immigrant, women, and depression. **RESULTS:** The process of acculturation and associated stressors may have a negative effect on the mental health of women of Mexican origin residing in the United States. Separation from family, harmful interpersonal relationships, unmet economic needs, conflict, and isolation may contribute to depression in this population. **CONCLUSIONS:** More research is needed on the influence of family and economic strain as well as the effectiveness of assessments and interventions for depression in Mexican and Mexican American women, especially for those living in emerging Latina/o immigrant communities.

Keywords: Latinas; depression; Hispanic; women; Mexican

### **Article:**

#### **BACKGROUND**

Latinas/os (the term *Latinas/os* will be used throughout this article to represent various terms used to identify Spanish-speaking women and men of Latin American heritage, including Hispanics, Hispanic Americans, Spanish Americans, and Latin Americans) are the largest minority population in the United States, making up 14.5% of the population (U.S. Census Bureau, 2005a). Sixty-four percent of Latinas/os are Mexican (U.S. Census Bureau, 2005a). Latinas/os are expected to make up nearly 25% of the U.S. population within the next 50 years (U.S. Census Bureau, 2004).

At the same time, *Healthy People 2010* (U.S. Department of Health and Human Services, 2000) reports disparities in the use of the mental health system by Latinas/os, who receive fewer mental health services than other groups even though the prevalence of mental illness in Latinas/os is similar to that in other ethnically/racially diverse groups (Alegría, Mulvaney-Day, Woo, et al., 2007; National Healthcare Disparities Report, 2005; Vega et al., 1998). Studying the quality of care for depression and anxiety disorders, Young, Klap, Sherbourne, and Wells (2001) reported

that only 24% of Latinas/os received appropriate mental health care, compared with 34% of Whites.

Depression is more prevalent in Latinas than Latinos (Alegría, Mulvaney-Day, Torres, et al., 2007). Latinas/os also experience more depression and are less likely to receive mental health support than White women and African American women. Specifically, 13.8% of Latinas, 11.7% of African American women, and 7.1% of White women report poor mental health, and 17.3% of Latinas, 11.7% of African American women, and 7.1% of White women rarely receive mental health support (U.S. Department of Health and Human Services, 2007). Attention to the mental health needs of specific Latina/o subgroups (e.g., Cubans, Dominicans, Mexicans, Puerto Ricans, etc.) is important because of varying and unique demographic characteristics, including but not limited to immigration status, educational attainment, employment status, and earned income levels (Harris, Edlund, & Larson, 2005; Pew Hispanic Center, 2002, 2005a, 2006; President's Advisory Commission on Educational Excellence for Hispanic Americans, 2003; Rosselló & Bernal, 1999; Stacciarini, O'Keefe, & Mathews, 2007).

Latinas of Mexican origin living in the United States are the focus of this review because almost two thirds of the U.S. Latina/o population is of Mexican origin (Pew Hispanic Center, 2005b). In addition, the Latina/o population in emerging communities located in nontraditional, nongateway states (e.g., Georgia, Indiana, Iowa, North Carolina, South Carolina, Tennessee, and Utah) compared with urban communities in states with traditionally large numbers of Latinas/os (e.g., California, Florida, New York, and Texas) is growing (U.S. Department of Health and Human Services, 2001; Villalba, 2007; Wainer, 2004). Most of the Latina/o residents in these emerging communities are foreign-born, and about 73% of these foreign-born Latinas/os are Mexican (Pew Hispanic Center, 2005b).

The authors of this review are located in one of these emerging immigrant communities located in a nontraditional, nongateway state (North Carolina). The authors are also part of a larger interdisciplinary community-based participatory research team that conducts research on Latina/o mental health issues. Earlier studies by this research team have identified depression in adult Latina women of Mexican origin to be an issue of concern (Shattell, Hamilton, Starr, Jenkins, & Hinderliter, 2008), and no reviews of the literature could be found. A review of the literature was needed to increase the research team's knowledge about depression in adult Latina women of Mexican origin. This article synthesizes the research on depression in adult Latina women of Mexican origin residing in the United States and discusses nursing implications for the care of these women. For the purpose of this article, the authors use the term *depression* to refer to self-report of depressive symptoms, for example, on depression measurement tools such as the Beck Depression Inventory and the Center for Epidemiological Studies-Depression (CES-D) Scale. The goal of this review was to inform and give direction to future research and practice.

## METHODS

The Cumulative Index of Nursing and Allied Health Literature (CINAHL), MEDLINE (PubMed), and PsycINFO databases for the years 2000 through 2008 were searched using the keywords Latina, Latino, Hispanic, women, and depression. Databases were further searched using the keywords Mexican American and Mexican immigrant. Initial searches of these three databases resulted in 494 articles (articles that appeared in more than one database were only

counted once). Article titles, abstracts, and text of articles were scanned for those that met the inclusion criteria for this systematic review. Inclusion criteria included the following: research studies published between 2000 and 2008, studies published in the English language, studies about depression, and studies with adult Latina women who were Mexican or Mexican American and who resided in the United States. The following articles were excluded based on our inclusion and exclusion criteria: 31 commentaries, theoretical articles, dissertations, or letters to the editor; 15 articles on methodology and instrumentation; 8 articles published in another language (Spanish); 169 studies about men, older adults (elderly), children, and adolescents; 40 studies about other Latina populations residing in the United States (e.g., Latinas from Puerto Rico or Cuba); 174 studies about other Latina populations living in other countries; medication trials; studies about depression and comorbid medical (e.g., diabetes, cancer, or HIV/AIDS) or other psychiatric illness (e.g., eating disorders); and 39 studies about mood disorder specifiers (e.g., with catatonic features, with melancholic features, or with postpartum onset) describing current or most recent episodes. The reference lists of articles meeting these inclusion criteria were scanned to identify additional articles. The final systematic review consisted of 18 articles that met our inclusion criteria, that is, studied depression in Latina women of Mexican origin residing in the United States; they are shown in Table 1. Studies identified in the systematic review, includes the author(s) and year, methods, sample, and general findings for the studies included in this review. Studies in this article are categorized according to themes found in this literature: acculturation, family roles and responsibilities, economics and education, and service use.

## RESULTS

### *Acculturation*

Several studies have suggested that mental health grows worse with increased acculturation (Crockett et al., 2007; Heilemann et al., 2002; Hiott et al., 2006; Wilkinson et al., 2006). For example, among Mexican women residing in the southeast United States for less than 5 years, one quantitative descriptive study of 150 recent immigrants from Mexico found that decline in mental health was associated with more time spent in the United States (Hiott et al., 2006). Also, in a quantitative descriptive study of a convenience sample of 315 Latina women of Mexican origin who were between the ages of 21 and 40, Heilemann et al. (2002) found that exposure to the United States in childhood correlated with a higher prevalence of depression and a lower level of life satisfaction. When asked to rate their own health status, U.S.-born women of Mexican origin reported better health but higher depression rates than women born in Mexico (Wilkinson et al., 2006). Furthermore, in a study of 148 Mexican American college students (67% of whom were women), Crockett et al. (2007) found that increased acculturative stress was associated with increased anxiety and depression in both men and women. These findings are consistent with those of Finch et al. (2000), who studied perceived discrimination, acculturative stress, and depression in a sample of 3,012 Mexican and Mexican American adults aged 18 to 59. These results suggest that higher levels of depression may be associated with higher levels of acculturation and associated stressors in women of Mexican origin residing in the United States.

However, a study of Mexican immigrant women that based acculturation on variables related to retention of cultural value and adaptation to U.S. society found no direct relationship between acculturation and depression (McNaughton et al., 2004). McNaughton et al. (2004) studied the relationships between maternal and child mental health, family functioning, family hardiness,

and acculturation in an urban Chicago sample of 182 women and their children who were in 4th and 5th grade. Acculturation was measured using the Acculturation and Structural Assimilation Scale, and no relationship between acculturation and maternal depression was found. Even when only English language acquisition and time spent in the United States were used to test this relationship, none was found. There was, however, a strong positive correlation between maternal depression and poor family functioning and an inverse relationship between maternal depression and family hardiness. Although most of the research supports the relationship between acculturation and depressive symptoms in Latina women of Mexican origin, the pattern of conflicting findings suggest that further study is needed.

### *Influence of Family Roles and Responsibilities*

Mexican women who put the needs of their children before their own (Mann & Garcia, 2005) may feel useless if they are unable to provide the material needs required for their family's livelihood (Heilemann et al., 2004). In a qualitative ethnographic study of health perceptions of 13 highly acculturated (based on language) Mexican American women in the southwestern United States, Mendelson (2002) found that "the participants were mothers first and foremost . . . they kept their children and their role as parents at the forefront of their discussion of health perceptions" (p. 213). The women in Mendelson's study viewed health from a holistic perspective that included not only physical, emotional, spiritual, and social components but also as being inseparably interwoven with their family relationships, especially with their relationships with their mothers. According to Mendelson, "Health exceeded the sum of these components; it was an embodied experience that transcended illness and was grounded in their relationships with their family and supported by their spirituality" (p. 213). Familial discord caused emotional distress. These findings are supported by Grzywacz et al. (2005) who used qualitative and quantitative methods to study the work and family experiences of Mexican immigrants who had immigrated to the southeastern United States within the past 5 years. Grzywacz et al. (2005) found a relationship between work– family stress and depression among their sample of Mexican women working in the United States. Women who reported high levels of family stress had higher rates of depression (Aranda et al., 2001; Grzywacz et al., 2005; McNaughton et al., 2004).

Conflict in familial relationships is often a source of stress and can lead to depression in women.  
Aranda

**TABLE 1. Studies Meeting the Inclusion Criteria**

<b>Author (Year)</b>	<b>Study Design and Purpose</b>	<b>Methods and Sample</b>	<b>Sample</b>	<b>General Findings</b>
Alegría, Mulvaney-Day, Torres, et al. (2007)	Quantitative; secondary analysis; examined the prevalence of psychiatric disorders across Latino subgroups	Data from the National Latino and Asian American Study (NLAAS), a national epidemiological household survey of Latinos	$n = 868$ Mexican adults	Increased rates of psychiatric disorders among U.S.-born, English language-proficient, and third-generation Latinos
Alegría, Mulvaney-Day, Woo, et al. (2007)	Quantitative; secondary analysis; examined correlates and rates of past-year mental health service use in a national sample of Latinos	Used data from the NLAAS, a national epidemiological household survey of Latinos	$n = 868$ Mexican adults	Rates of overall mental health service use and specialty service use were lower among Mexicans
Aranda, Castaneda, Lee, and Sobel (2001)	Quantitative; examined gender differences in the rates of depressive symptoms as well as differences in factors associated with depressive symptoms	Measures: Beck Depression Inventory (BDI), Hispanic Stress Inventory (HIS), Coping Responses Inventory-Adult form (CRI-A), and Dimensions of Social Support Scale (DSSS)	$n = 83$ Adult women; convenience sample from rural and urban Pennsylvania and from Los Angeles	Family-cultural conflict, marital-partner relationship, low social support, and low educational levels significantly predicted depressive symptoms
Crockett et al. (2007)	Quantitative; examined the relationship between acculturative stress and psychological functioning and the buffering effects of social support and coping	Measures: Beck Anxiety Inventory; Social, Attitudinal, Familial, and Environmental (SAFE) Acculturative Stress Scale; Network of Relationships Inventory (measures parent and peer support); and COPE inventory (measures coping)	$n = 99$ Female Mexican American college students; convenience sample from Texas and California	Acculturative stress was associated with higher levels of anxiety and depressive symptoms. Parental social support and active coping were buffers against acculturative stress
Finch, Kolody, and Vega (2000)	Quantitative; investigated the direct and moderating connections between perceived discrimination, acculturative stress, and mental health	Used data from the Mexican American Prevalence and Services Survey, which included the Center for Epidemiological Studies-Depression (CES-D) Scale	$n = 3,012$ Adult Mexican-origin participants from Fresno, California	Discrimination was directly related to depression, but this effect was moderated through nativity/country of residence, English-language, acculturation, gender, and country of education variables.
Fox, Burns, Popovich, and Ilg (2001)	Quantitative; described the prevalence of depression in immigrant Mexican women and refugee Southeast Asian women	Recruited from women seeking care at a health clinic. The BDI and the DSM-IV criteria were used to screen for depression in the Mexican immigrant women	$n = 220$ Mexican immigrant women; convenience sample	Moderate levels of legal status acculturative stress were especially depressive for native-born U.S. residents. Twenty-four percent ( $n = 52$ ) of the Mexican immigrant women met criteria for depression

*(continued)*

**TABLE 1. (continued)**

<b>Author (Year)</b>	<b>Study Design and Purpose</b>	<b>Methods and Sample</b>	<b>Sample</b>	<b>General Findings</b>
Gee, Ryan, Laflamme, and Holt (2006)	Quantitative; secondary analysis; examined the relationship between self-reported discrimination and mental health states among African descendants, Mexican Americans, and other Latinos	Data were from the New Hampshire Racial and Ethnic Approaches to Community Health (NH REACH) 2010 Initiative. Measures: Mental Component Summary (MCS12) of the Medical Outcomes Study Short Form 12 and measured discrimination with questions related to respondents' ability to achieve goals, discomfort/anger at treatment by others, and access to quality health care	<i>n</i> = 141 Mexican American women	Discrimination may be an important predictor of poor mental health status among Latino immigrants
Grzywacz, Quandt, Arcury, and Marin (2005)	Mixed methods; examined work-family stress from the perspective of Mexican immigrants who had been residing in the United States for 5 years or less	Data were collected from two distinct samples. In-depth interviews were conducted with 22 Mexican immigrants from North Carolina who were referred by community-based organizations. Measures: SAFE Acculturative Stress Scale, work-family strain, Personality Assessment Inventory (PAI), and CES-D	<i>n</i> = 68 Women immigrants from Mexico who had been in the United States for fewer than 5 years	Separation from family is a significant stressor for recent immigrants from Mexico
Harris et al. (2005)	Quantitative; secondary analysis; compared rates of mental health problems and use of mental health care across multiple racial and ethnic groups	Used data from the 2001-2003 National Surveys on Drug Use and Health	<i>n</i> = 134,875 Adults	The rates of use of mental health care among Mexicans were significantly lower
Heilemann, Coffey-Love, and Frutos (2004)	Qualitative; analyzed and described reasons given for most recent episode of sadness, hopelessness, or depression	Survey methods This study reports data from participants who were depressed (scored 16 or higher on the CES-D) and who responded to open-ended questions. Grounded theory was used to analyze the data	<i>n</i> = 107 Women of Mexican descent; convenience sample from community clinics and an immersion school in northern California	Reasons for depression included the following: partner issues, family issues, feelings of being alone, inability to provide for material needs, and bodily symptoms

(continued)

**TABLE 1. (continued)**

<b>Author (Year)</b>	<b>Study Design and Purpose</b>	<b>Methods and Sample</b>	<b>Sample</b>	<b>General Findings</b>
Heilemann and Copeland (2005)	Quantitative; described and compared intragroup differences among three groups of help-seeking women	Survey methods; analysis of variance tests comparing the three groups of help seekers using variables such as age, income, mastery, resilience, life satisfaction, CES-D, and Impact of Events Scale-Revised (IES-R) scores	<i>n</i> = 68 Convenience sample from family health community clinics in urban northern California.	Forty-six percent ( <i>n</i> = 31) sought help from a professional health care provider (doctor, therapist, or counselor); 26% ( <i>n</i> = 18) sought help from familial sources (spouse or relative); and 28% ( <i>n</i> = 19) sought help from "other/multiple" sources of help
Heilemann, Lee, and Kury (2002)	Quantitative; descriptive study detailing depressive symptoms in Latinas of Mexican descent and contributing factors to high and low levels of depression	Measures: demographic questionnaire, Resilience Scale (Spanish translation), Mastery Scale (Spanish translation), and CES-D (Spanish version)	<i>n</i> = 315 Convenience sample from family health clinics	Women who spent their childhood in Mexico had fewer depressive symptoms; negative factors (e.g., poverty, substance abuse) accounted for less variance in depressive symptoms compared with positive factors (e.g., resiliency, life satisfaction)
Hiott, Grzywacz, Arcury, and Quandt (2006)	Quantitative; explored stressors that accompany immigration from Mexico and the effect of these stressors on immigrants' mental health	Measures: CES-D and PAI	<i>n</i> = 68 Women immigrants from Mexico from rural Southeast (United States)	Thirty-nine percent had significant anxiety; almost 40% were significantly depressed (defined as having scores of 16 or higher on the CES-D)
Mann and Garcia (2005)	Qualitative; exploratory study of Mexican Latinas' methods for coping with depression, the type of resources and interventions they use, and reasons for choosing those services	Focus group methodology was used to collect responses to a semistructured moderator's guide; five focus groups in total	<i>n</i> = 24 Self-selected from clinics, community centers, and one university campus	Women with depression first dealt with the depression with self-reliance, then turned to family and friends for assistance and support; Barriers to successfully coping with depression included stigma associated with being depressed, lack of support from spouses, logistical issues, and weak empathy from medical staff; community providers must account for child care, transportation, intervention length, and Spanish proficiency of service provider

(continued)

**TABLE 1. (continued)**

<b>Author (Year)</b>	<b>Study Design and Purpose</b>	<b>Methods and Sample</b>	<b>Sample</b>	<b>General Findings</b>
McNaughton, Cowell, Gross, Fogg, and Ailey (2004)	Quantitative; secondary analysis; described mental health symptoms in Mexican immigrant mothers and their relationships to child mental health, family functioning, and acculturation	Used data from the Rush Mexican American Problem Solving Program, which is a mental health intervention for Mexican immigrant women and their school-age children. Measures: Hopkins Symptom Checklist (HSC; which has depression and anxiety subscales); Everyday Stress Index (ESI); Feetham Family Functioning Survey (FFFS); Family Hardiness Index (FHI); Acculturation and Structural Assimilation Scale (ASAS)	<i>n</i> = 182 Mexican women and their children who reside in the United States	Depression and anxiety were highly correlated with family functioning and mother's stress levels
Mendelson (2002)	Qualitative; exploratory study of health perceptions of acculturated Mexican Latinas as well as their attitudes toward health seeking behaviors and the roles of Mexican Latinas in promoting household health	Ethnographic methods	<i>n</i> = 13 All were permanent U.S. residents and English speakers (related to their classification as "acculturated"); purposive, convenience sample	Participants reported stress related to living far from their families, particularly their mothers, or lack of understanding between themselves and their relatives (namely, their mothers); the use of prayer and spirituality was recommended for dealing with difficult situations
Schmalung and Hernandez (2005)	Quantitative; compared detection of depression from primary care providers' assessments with structured diagnostic interviews	Depression was detected by researchers through structured diagnostic interviews using the Patient Health Questionnaire (PHQ) and the Primary Care Evaluation of Mental Disorders (PRIME-MD); researchers then reviewed participants' medical records for any reference to depression or depression treatment	<i>n</i> = 408 Women; convenience sample from two primary care clinics in rural Texas	Thirty-nine percent of Mexican American patients seeking care in a primary care clinic met criteria for one or more depressive disorders; 41% of participants reported anhedonia, dysphoria, or both; providers detected only 30 of the 146 patients with depressive disorders

(continued)

**TABLE 1. (continued)**

<b>Author (Year)</b>	<b>Study Design and Purpose</b>	<b>Methods and Sample</b>	<b>Sample</b>	<b>General Findings</b>
Wilkinson et al. (2006)	Quantitative; exploratory study to establish how self-related health (SRH), acculturation, and socioeconomic status (SES) factors predict health indicators in Mexican-born Latinas compared with U.S.-born Mexican Latinas	Participants were recruited using random-digit dialing, intercept, and door-to-door attempts from an ongoing population-based cohort of Mexican households created by the authors' university-affiliated department; structured interviews were conducted with participants using bilingual interviewers; interviews included but were not limited to questions about general health, behavioral risks, SES, and residential history; instruments included a demographic questionnaire, health behavior index (including depression), Bidimensional Acculturation Scale for Hispanics, and SES index	<i>n</i> = 631 Matched pairs of Mexican-born and U.S.-born Mexican Latinas	Higher levels of acculturation associated with better SRH; findings on SES and SRH were inconclusive because Mexican-born participants were more likely to be of a lower income status than U.S.-born Mexican Latinas; depression was shown to be the strongest predictor of SRH, partially related to the experiences during and after immigration

et al. (2001) found that family–culture conflict and marital discord were significant predictors of depression in low-income Mexican American women, most of whom were immigrants living in Mexican American barrios. Unmet expectations in familial relationships were strongly associated with depression among Mexican immigrant women in a study by McNaughton et al. (2004). Consistent with these findings, when Heilemann et al. (2004) asked a group of 107 women of Mexican origin about their reasons for depression, three of the six reasons involved family. Partner conflict and isolation as a result of the death of or separation from family members were two common reasons for depression (Heilemann et al., 2004). Partner conflict may be exacerbated by the role changes immigrant women experience, including working outside the home, which can result in a shift to a more egalitarian spousal relationship with accompanying conflict (Fox et al., 2001).

Isolation is a common finding in studies that examined factors perceived as causing depression in Mexican and Mexican American women (Hiott et al., 2006). The isolation may be related to unfulfilled relationships or it may result from separation from or loss of family. Women may experience significant losses of social support and a sense of isolation on immigrating to a different country, and this loss may be manifested in a grieving process. Unresolved grief can in

turn lead to depression (Fox et al., 2001). Among a group of Mexican immigrants, separation from family was strongly associated with increased depressive symptoms for women, though not for men (Hiott et al., 2006). These findings suggest that negative relationships, unmet familial needs, conflict, and isolation may be risk factors for depression in women of Mexican origin who reside in the United States.

Familial influences may also have a detrimental effect on Mexican women seeking assistance for their depression. For example, Latinas of Mexican descent who “seek emotional help only from familial sources may continue to have high levels of distress” (Heilemann & Copeland, 2005, p. 200). This becomes particularly relevant to general health care providers because Latinas/os of Mexican descent often consider them as the front line of mental health care (Heilemann & Copeland, 2005).

### *Influence of Economics and Education*

According to the U.S. Census Bureau, 22% of Latinas/os live below the federal poverty line compared with 10.6% of Whites (U.S. Census Bureau, 2005b). These numbers suggest that many Latinas/os face financial hardships, another significant cause of stress. Higher income, however, may trigger other stressors. According to Alegría, Mulvaney-Day, Torres, et al. (2007), “access to education and increased income may also increase exposure to experiences of discrimination and prejudice which have been associated with psychiatric distress” (p. 74). In addition, factors other than income (e.g., acculturation, separation from family) may be more important than income alone. For example, Heilemann et al. (2002) found that “regardless of higher incomes, women who were exposed to the US in childhood reported a higher level of depressive symptoms than women who were not exposed to the US until adulthood” (p. 180), and Grzywacz et al. (2005) found that separation from family was a greater stressor for women than men, and for women, it was a greater stressor than economics.

Heilemann et al. (2002) studied risk of and protective factors for depression in a convenience sample of 315 Mexican and Mexican American adult women who were recruited from family health clinics in an urban area of northern California. They found an association between women’s inability to meet material needs and increased depressive symptoms. Hiott et al. (2006) measured economic hardship with one question: “How well does the amount of money you have take care of your needs?” An ability to meet daily material needs may be more important for women than income as a measure of economic strain.

Of the racial and ethnic groups studied—African American, Asian, Mexican, Central and South American, other Hispanic-Latino groups, and American Indian/Alaskan Natives—Harris et al. (2005) found Mexicans to be the least likely to have a college education. Also, census data reveal that Mexicans have lower proportions of high school diplomas, bachelor’s degrees, or graduate education than other Latinas/os (Pew Hispanic Center, 2005a, 2006; U.S. Census Bureau, 2002). One study found that education level was the only social status variable predictive of depressive symptoms among Mexican American women (Aranda et al., 2001). Those who receive less education are also far less likely to receive needed medical care than those with more education (Adams, Dey, & Vickerie, 2007). Neither income nor educational level alone can predict depression in women of Mexican origin; moderating and mediating variables such as acculturation (time in the United States), geographic location (e.g., established or emerging

immigrant community), individual coping styles, separation from family, stressors within the context of home (family–cultural, marital- partner, and familial relationships), and service use need to be examined.

### *Influences of Service Use*

Whereas some studies suggest that Mexicans and Mexican Americans have fewer mental health problems than other Latino groups (Alegría, Mulvaney- Day, Torres, et al., 2007; Harris et al., 2005), other studies suggest that the rate of depression in women of Mexican origin increases with increasing acculturation (Heilemann et al., 2002; Hiott et al., 2006; Wilkinson et al., 2006). According to data from the National Latino and Asian American Study (Alegría, Mulvaney-Day, Woo, et al., 2007), Mexicans in the United States are less likely than Cubans, Puerto Ricans, and other U.S. Latino populations to receive mental health services (from either general medical or psychiatric providers), to experience satisfaction with mental health services, and to perceive mental health services to be helpful. Significant numbers of women of Mexican origin with depressive symptoms do not seek treatment (Alegría, Mulvaney-Day, Woo, et al., 2007; Heilemann & Copeland, 2005; Mann & Garcia, 2005; U.S. Department of Health and Human Services, 2000).

Many factors affect mental health service use. Barriers include an emphasis on familial concerns rather than individual concerns, culturally incongruent resources, discrimination, and lack of financial capability (Shattell, Villalba, et al., 2008). Vega and Alegría (2001) suggest that insurance availability, bilingual support, and knowledge of care are important to increase access to quality care. In addition, Heilemann and Copeland (2005) found that Mexican women with depression reporting less severe symptoms are less likely to seek assistance for their symptoms from mental health professionals or family members, preferring to speak with friends, clergy, or *curanderos* (indigenous healers).

Furthermore, Mexican and Mexican American women may not seek mental health treatment because of conflicting cultural values that place family goals before individual goals (Alegría, Mulvaney- Day, Woo, et al., 2007). With this emphasis on the collective, there is a sense of self-reliance among families coping with mental health problems as well as a sense of shame for the family when personal problems are disclosed (Alegría, Mulvaney-Day, Woo, et al., 2007; Vega & Alegría, 2001). This sense of shame makes it difficult for women to seek help (Aranda et al., 2001; Heilemann et al., 2004; McNaughton et al., 2004; Mendelson, 2002). Thus, women cope with depression first through personal individual means, such as spirituality and keeping busy (Mann & Garcia, 2005; Mendelson, 2002). When necessary, women share their feelings with family members, usually female family members (Mendelson, 2002). However, reaching outside immediate networks to seek help for depression is difficult, in part because this requires emphasizing the individual's problems and ways of helping the individual.

Depression screening, assessment, and treatment are often inadequate (Young et al., 2001). In a study of 486 low-income Mexican American adults seeking care in one of two primary care clinics, Schmalings and Hernandez (2005) found 146 individuals who met the *DSM-IV* diagnostic criteria for major depressive disorder ( $n = 138$ ), dysthymia ( $n = 58$ ), and depressive disorder not otherwise specified ( $n = 6$ ), using depression screening and diagnostic interviews. Unfortunately, the clinic health care providers only detected 30 individuals (out of 146) during routine care.

Among those who do seek help, the assistance given may even increase the stress that Latina women of Mexican origin experience. Mexican immigrants report more discrimination in health care than other Latina/o immigrants (Gee et al., 2006), and they report that this discrimination makes achieving goals more difficult. Perhaps related to their sense of discrimination, Mexicans and Mexican Americans report less satisfaction with mental health services than other Latina/o groups, although those who have resided in the United States for more than 5 years report more satisfaction than those newer to the United States (Alegría, Mulvaney-Day, Woo, et al., 2007).

Finally, more Mexicans and Mexican Americans than other Latina/o subgroups report that they delayed getting or did not receive needed health care because of cost (Adams et al., 2007). In addition, Mexican and Mexican Americans often lack health insurance. Indeed, examining data from the national surveys on drug use and health, Harris et al. (2005) found that Mexicans, Central Americans, and South Americans were least likely to have health insurance. Consistent with these findings, 34% of Latinas/os under the age of 65 are uninsured, 2.5 times the percentage of non-Latina/o Whites. The rate of uninsured Mexicans and Mexican Americans is alarming, making health care more expensive for these individuals and, therefore, infrequently used (Adams et al., 2007). This financial stress may contribute to depressive symptoms (Heilemann et al., 2004; Mann & Garcia, 2005; Mendelson, 2002).

## DISCUSSION AND IMPLICATIONS

The literature on depression in Latina women of Mexican origin residing in the United States provides a glimpse into the interconnectedness and complexities affecting their mental health. Although acculturation and associated stressors warrant further research, findings suggest that with increased time in the United States, there are increased levels of depression among women of Mexican origin (Crockett et al., 2007; Heilemann et al., 2002; Hiott et al., 2006; Wilkinson et al., 2006). Additionally, family conflict and separation from family have been associated with increased depressive symptoms in women (Aranda et al., 2001; Fox et al., 2001; Heilemann et al., 2004; McNaughton et al., 2004; Mendelson, 2002). These findings suggest that positive and negative perceptions and experiences with U.S. society should be included in assessments for depression to identify stressors and internal conflict in the transitioning period of acculturation. Programs to help immigrant women understand U.S. institutions such as health care and educational systems may also be beneficial.

Nurses need to be aware that separation from family is a significant stressor, which can contribute to depression among Mexican and Mexican American women residing in the United States. Hiott et al. (2006) suggest that health history forms should include questions regarding separation from family and social networks. Because of the strong association between family roles and relationships and depression, familial relationships, which include immediate family members as well as extended family members, such as siblings, grandparents, aunts, and even cousins, should be assessed for conflict or positive support (Santiago-Rivera, Arredondo, Gallardo-Cooper, 2002). Additionally, if women place more value on the collective than the individual, providers should acknowledge these values and address problems in a familial context. Programs providing support for family relationships and social support networks may be beneficial.

It is important for nurses to understand the experience of depression among Mexican and Mexican American women. Because nurses are often the first health care providers many of these women meet, it is important that nurses convey interest, respect, and a safe environment for women to share their concerns and symptoms. Consequently, understanding Mexican and Mexican American cultures, the process of acculturation, and potential barriers to mental health care is paramount. Assessing Mexican and Mexican American women for culturally specific as well as universal signs of depression will improve the prospect of early intervention.

Nurses should refer Mexican and Mexican American women to appropriate and culturally sensitive providers. Nurses can also lobby for improved mental health care for all Mexican and Mexican American patients and support efforts in this direction. To adequately address mental health issues in Mexican women, socioeconomic and educational attainment factors, specifically, as well as discrimination must be addressed.

Culturally sensitive education of patients and families regarding depression is also important. This can be done by bilingual nurses or with written materials in Spanish such as flyers, booklets, and comic books or through *novela* (Spanish-language soap opera) on CDs or DVDs.

Many of the studies in this systematic review were conducted in gateway states such as California and Texas. More research is needed with new, emerging Mexican immigrant women living in non- gateway cities and states. Further investigation of the prevalence of depression and of the mental health needs of these women is needed. Using community-based participatory research groups to better understand the manifestation and treatment of depression may be helpful in expanding nurses' understanding. Studies to clarify the effects of acculturation on depression in Mexican and Mexican American women are also needed. More research is needed on the influence of family and economic strain as well as the effectiveness of assessments and interventions for depression in Mexican and Mexican American women, especially those living in emerging immigrant communities.

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