

It has long been understood that families are the primary source of socialization and the main carrier of cultural messages from generation to generation. In addition, strong social ties are important influences in any individual's manifestations of illness and behaviors. Psychology, psychiatry, anthropology and epidemiology have paid increasingly more attention to the issue of culture and the way it defines, influences, and explains mental health in various groups. Specifically, studies have shown that "group closeness and exclusivity increases the likelihood of an individual's responding to a medical problem in a way that is consistent with his sub-cultural background" (Geertsen et al, 1975; p. 233).

When working with members of any cultural or ethnic group in clinical settings, it is important to consider the ways in which their group affiliations and personal identities influence their lives. This study examines how these affiliations and identities influence their struggle with adherence to antidepressant medications. Given the rise of US residents who identify as Latinos and the disparities that have been documented in Latino mental health treatment, we felt it was important to look at the ways in which family relationships among Latinos influence a patient's adherence with antidepressant medication. Oftentimes when looking at family relationships among Latinos, the construct of *familismo* is invoked.

The concept of *familismo* (familism) has been introduced in various ways in the field of Latino mental health. Familismo has been studied for over 60 years, was initially defined generally as the "normative commitment of individuals to their family and family relationships" (Villarreal, Blozis & Widaman, 2005; p 410). This tendency to value family relationships over other social relationships usually includes concepts such as *respeto* (respect) to refer the hierarchical nature of family dynamics (Garcia-Preto, 2005). The concept of familismo can also

be understood as a manifestation of the collectivist nature of Latinos, where the benefits, status, and general well-being of the group take precedence over those of an individual.

Researchers have identified two domains of familism that are important to understand: attitudinal and behavioral (Villareal et al, 2005). They define attitudinal familism as the ideological beliefs related to family construct and relationships, including loyalty and reciprocity. Behavioral familism captures the behavioral aspects of what a person might do for family members, such as helping with childcare or with finances. In their article, Villarreal and colleagues provide a brief history of the study of familism. They note that Latinos have come out higher than Anglos on various indices of family commitment, indicating its importance and relevance for Latino health research. They further specify that family relationships for Latinos tend to include members outside of the nuclear family, and individuals are generally raised to depend on the family, which contrasts to other mainstream cultures where individuals are raised to be independent of the family.

In addition to providing some historical background of familism, the aim of their study was to determine the validity and factorial structure of familism with a representative sample of Latinos in the U.S. They focused on the attitudinal, not behavioral aspects of familism. The items on their scale were meant to capture the ideological beliefs related to family as opposed to behavioral aspects of what they might do for family members. They found that the concept of familism was important regardless of country-of-origin. Other studies have further broken down the construct of attitudinal familismo (Lugo Steidel & Contreras, 2003). Their study found that there are four constructs that together make up attitudinal familismo: familial support, familial interconnectedness, familial honor, and subjugation of self for family. This last construct was

somewhat new to the field, and the authors defined it as the belief that a person must yield and be submissive to the family.

Studies examining issues of resilience and coping in Latinos have identified family connections as a key domain. A very interesting study carried out with Mexican-origin migrant farm workers found several ways in which cultural values influenced the participants' lives. Parra-Cardona and colleagues (2006) conducted an analysis of interviews with a sub-sample of 13 women of Mexican origin, who were migrant workers or had partners who were migrant workers, and who participated in a larger, longitudinal study. They were interested in exploring the families' resilience in the face of these difficult life circumstances. Using the grounded theory approach of open, axial, and selective coding, they came up with six broad categories that explained the participants' life experiences. One of their six categories was *estando todos juntos* (being all together). Thus they provided support for the validity of the cultural value of familismo as evidenced in the ways in which their participants spoke about the importance of extended family support during crises. Their findings also point to the importance of working hard, referring not only to the value of literally working hard but also to the value of being committed parents, having solidarity for their community and not having to depend on government aid.

The role of family has been studied extensively in clinical studies of cultural values as it relates to family caretaking. Studying the concept of *nervios* as an interpretation of schizophrenia in Mexican-American families, Jenkins (1988) highlighted the importance of family and cultural explanations in health care seeking processes and in treatment. As stated in her article, "Evaluations by family members influence affective and behavioral responses to the problem, decisions to obtain treatment, and the type of treatment sought" (p. 304). Jenkins

interviewed Mexican family members of patients with schizophrenia in an effort to understand their conceptualization of the disease. She found that many used the label *nervios* to describe what their family member was experiencing. When she looked at the two most commonly used descriptions of *nervios*, Jenkins found that they revealed the complex relationship among family roles, cultural values, and the actual symptom and illness interpretations (1988).

Specifically, Jenkins (1988) found that the category of *nervios* described as being nervous, having difficulty sleeping, and being emotionally overwhelmed were most often found among women. In contrast, the type of *nervios* described as having a quick temper, being easily angered and irritable was most often reported among men. Family members actively tried to seek treatment and understand what their ill family members were going through, accommodating their needs as best they could. The family members interviewed tended to be very concerned and felt very sad about their ill family members' conditions. Again, this study highlights the importance of family unity and the desire to work to help each other out.

Guarnaccia and colleagues (1992) also discuss the importance of family involvement in caring for ill family members, noting the strong family loyalty that was evident in their interviews. Using data from 45 Latino families with an ill family member, they interviewed the primary care giver in each family. They found that the primary caretakers were more likely to turn to other family members than to professionals for advice regarding how to deal with their ill family member. They also turned to family for support and emotional release when they were having difficulties. In addition, most of the ill relatives lived within proximity to their families, if not with a family member. Family caretakers often expressed that they believed it was best for their ill family member to be with family rather than in a hospital or other institution (halfway house, etc). Among Latinos, the commitment of the family to help the ill family member

extended to spouses, parents and siblings. This contrasted with European-American individuals where family beyond parents were much less likely to be involved in caregiving.

Family involvement in treatment has been found to increase adherence in Latinos with schizophrenia (Hosch et al., 1995). The authors reviewed the records of 193 closed cases of Latinos with schizophrenia in El Paso, Texas. They looked at motivation for treatment, which they defined as keeping appointments, asking for refills, picking up medication, and asking for medication adjustments. They also looked at acculturation by using language spoken at home, and whether their documents were completed in English or Spanish. In addition to the finding that family support was related to adherence, they found that the higher the motivation and the older the patient, the more likely they were to adhere to treatment. The authors concluded that families should be incorporated into the mental health treatment setting in order to increase adherence of their ill family members.

Adherence with medications is an area of concern for providers who work with various ethnic minority groups. There is evidence that low treatment adherence is of specific concern among Latinos, as it appears to be more frequent (Interian et al, 2007). There have been several studies that have documented low treatment adherence among Latinos who are prescribed antidepressant medications (Sanchez-Lacay et al, 2001; Sleath et al, 2003; Miranda & Cooper, 2004).

The role of the family not only influences the degree to which an ill family member adheres to treatment, it also affects the way an individual rates his or her own health. Using the nationally representative sample of Latinos from the National Latino and Asian American Study (NLAAS), Mulvaney-Day and colleagues (2006) measured self-rated mental and physical health status and looked at how it was affected by social connection, family and social support, and

family cultural conflict. Although self-rated health was related to all the scales, they found that self assessed mental health status among Latinos had higher significant associations with family support and social support. Furthermore, their findings suggested that family support provided a strong protective factor regardless of the individual's socioeconomic status or language status.

Thus there is clear evidence about the importance of families in the lives of Latinos suffering from mental illness. Equally evident is the fact that adherence is less than optimal for Latinos who are prescribed antidepressants. Therefore, I decided to explore general questions about Latino community members' experiences with antidepressant medication treatment for their primary diagnosis of major depressive disorder. I was most interested in finding out what cultural values influenced people's decisions to take medications or not. By answering these questions regarding participants' values, this study set the groundwork for further analysis. This in turn helped inform an intervention aimed at increasing participant motivation to take antidepressant medication, and to help participants make a decision they are comfortable with regarding their providers and their treatment plan. This study gives voice to Latino community members, creating a venue in which their words can be used to express to other researchers and clinicians what community members experience when struggling with depression and the decision to take antidepressant medication. This paper examines role of family influence and how familismo affected adherence among this diverse Latino sample.

The data presented herein describe one of the major cultural code categories that arose from the transcripts across all six focus groups. I use a definition of familismo that includes both attitudinal and behavioral components of the construct, and includes the way family members influenced their ill relatives' decisions about antidepressant medication in ways that were treatment supportive and treatment discouraging. This study helps to further clarify the meaning

of familismo and the specific relationship among familismo, family influence, and mental health treatment.

## Methods

### *Setting and Sample*

Six focus groups were held in a local community mental health clinic with Latino patients with a primary diagnosis of Major Depressive Disorder who had received or were receiving antidepressant treatment. We recruited a total sample of 51 participants through referrals and direct contacts. Of these, only one person declined to participate and 20 were not enrolled due to problems contacting them and scheduling other participants. A total of 30 people participated in the focus groups, which were conducted between April and August 2006. Each participant completed a brief demographic questionnaire, the results of which are presented in Table 1.

Eighty percent of the sample were women; the average age of these participants was 47 (see Table 1). Half of the participants were Puerto Rican, 23% were Dominican, 17% were Mexican, and 10% were from other Latin American countries such as Nicaragua or Colombia. The average length of time living in the United States for these participants was almost 18 years. The largest proportion of the focus group participants (43%) had less than a high school education. In terms of their literacy rates, the majority of participants described being able to read Spanish “very well” (70%). When asked about their self-assessed English fluency, the majority of participants (83%) described it as “Not too well/cannot speak English.” The majority of participants reported that they spoke mostly Spanish with their family and friends (73% and 63%, respectively). The average length of time with a Major Depression diagnosis was 11 years and the average length of time on antidepressant medication was 9 years.

[Table 1 about here]

The participants for this study were mostly females who had been living in the United States for a significant portion of their adult lives but were monolingual Spanish speakers with a relatively low level of education. This sample is characteristic of others in the area of Latino mental health research as females generally tend to be over-represented in these samples and many community members are monolingual Spanish speakers with low education and low socioeconomic status (Cabassa, Lester, & Zayas, 2007; Martinez & Guarnaccia, 2007). This sample is interesting as most participants carry a diagnosis of depression for a long time and report having been on antidepressants for the majority of the course of their depression.

#### *Research Procedures*

After receiving IRB approval for the study research, team members met with key personnel in a community clinic to go over recruitment procedures. All members of the research team were bilingual, bicultural individuals who were able to match participants' language abilities. The inclusion criteria for participation in this study were that participants needed to be self-identified Latinos between the ages of 18 and 65, carry a primary DSM-IV diagnosis of major depressive disorder, and be currently prescribed antidepressant medications. An initial contact sheet was created to give to the direct service providers. These providers spoke to their patients about the study and had the prospective participants fill out the contact sheet and return it to the research team. We asked providers to identify their patients as generally adherent or nonadherent based on their knowledge and interactions with their patients. Eligibility was then confirmed by the author, and potential participants were invited to participate in a group discussion about their experiences with depression and their depression treatment.

The smallest group included three participants while the largest group had seven participants, for an average group size of 5 patients. Three groups were set up to include patients who were identified by their primary mental health provider as generally adherent with their antidepressant medications. Two additional groups were set up to include patients who were identified as generally nonadherent with their antidepressants. The last group was a mixed group in terms of level of adherence. I attended each group and took detailed notes during the focus group, while Dr. Alejandro Interian moderated and led the groups using the focus group guideline (See Appendix A). Each group lasted one and a half to two hours, refreshments were served at each focus group and participants received \$75 for their time at the conclusion of each group. Each focus group was audio taped. All participants were given a pseudonym to protect their identification.

### *Analysis*

We employed a grounded theory approach (Strauss & Corbin, 1998) to learn from Latinos, in their own words, what the specific barriers, complications, considerations, and attitudes were regarding taking antidepressant medication. Strauss & Corbin (1998) state that the use of grounded theory allows researchers to theorize while maintaining the integrity of the data collected. We wanted to use this information to build a general model of the factors that interact with each other when Latino community members are struggling with adhering to their antidepressant medication. This qualitative study was Phase I of a larger research project. The goal of the overall project was to develop a culturally sensitive intervention to help Latinos suffering with depression achieve a higher degree of antidepressant adherence.

We employed focus groups to explore the issue of adherence among depressed Latinos was carried out for various reasons. A qualitative methodology, particularly using focus groups,

is more conducive to exploration, since it allows us to better understand the nature and meanings behind adherence with medication from the Latino community members' perspectives (Morgan & Krueger, 1998). Focus groups, rather than individual interviews, were chosen as the method of data gathering not only because the group dynamics helped to bring out varying points of view as participants could compare and contrast their own stories, but also because they allowed the researchers to recruit a larger sample in a shorter period of time. This analytic approach is geared towards discovery, which was the aim of our study.

I transcribed each focus group and each transcript was transferred into a document file in the ATLAS.ti system. We coded each transcript independently, line by line, to identify the topics and themes that were emerging in the data. After half of the focus groups had been thus coded, a team meeting was held to discuss the independently created list of open codes. Through this process we were able to ensure not only that each code was being used in the same way, with the same definition, but also we were able to catch quotations that met the criteria for a code but were missed by one rater or another. Furthermore, working towards consensus served as an analytic process allowing our thinking and understanding about each code to deepen as a result. A coding manual was created to describe each code and to capture the frequency with which each code appeared across all transcripts (Appendix B). When all of the transcripts were coded, another team meeting was held to check agreement and concordance between the two raters.

### *Limitations*

This study was an exploratory, qualitative study that carried with it some limitations. We had a relatively small number of participants which makes it difficult to generalize the findings to other Latinos. In addition, we used a convenience sample of people who were already in treatment. In addition despite our best efforts to remain objective, there was a potential for

investigator bias given that the team included only the principal investigator and the research coordinator. We addressed investigator bias by holding team meetings to reach a consensus process. Finally, each patient participated in only one focus group. Future studies might allow participants to attend multiple groups in order to build trust. By building this trust, investigators might create an environment where participants feel more comfortable bringing up other topic areas that might not arise in an initial group.

## Results

The results presented in this article arose as a result of a broad question asking participants to define what being Latino/a meant to them. The specific concepts described herein arose of their own accord and were not directly inquired about or explored within the focus group discussions. Several categories emerged from the data that described the ways in which culture shaped participants' experiences with antidepressants. The four major categories that were relevant in this manner were *familismo* (familism), *trabajar/luchar/aprovechar* (work, struggle, take advantage), *poner de su parte* (do one's part), and religion. Though other themes also emerged that would fit under the umbrella of cultural considerations, these four were the most important as measured by the number of participants who raised the issue as a concern. Through the consensus process described above, 50 instances of familismo were coded across the six focus groups, and the concept of familismo was brought up by 22 (73%) of the participants.

Familismo refers to a strong family orientation, including the emphasis of family over non-family networks, that individual needs are subsumed under family needs, and that there is a strong weight given to issues of family, respect, functioning, caretaking, providing, etc. We also included statements that showed that the speaker did not want to burden their families with their

problems, at their own expense, which differs from not talking to family members due to their lack of understanding of the problem or due to fear of stigma. Finally, we also included examples that run counter to the idea of familismo because they illustrate the complexity of the construct.

Before exploring the relationship between familismo and depression treatment, it is important to understand how Latinos understood the meaning of family in a general way. A general component of Familismo is that of *respeto*, which is usually interrelated with generational dynamics and the value of respecting your elders. Respect and family unity were two important aspects in the lives of the focus group participants. Given that most of the participants were born outside of the U.S., the ideas of family unity and proximity take on the additional role of providing a sense of security and familiarity in a foreign context. The importance of remaining together becomes even more critical as family networks are disrupted due to the immigration process. Adriana, an immigrant from Mexico in her early 30s, stated,

*Como Latinos tenemos más unión familiar y somos mas alegres, que algunos Americanos, no todos.*

As Latinos, we have more family unity and we are happier than some Americans, not all.

One aspect of familismo is reflected in the desire to stay together not only in physical proximity but also by being emotionally close. When asked to describe what was important about being Latina, Laura, a Dominican woman in her late 40s, described the construct perfectly when she said,

*Queremos mucho a los hijos, los papas, todo, como queremos estar siempre unidos...Porque yo he oído muchas personas que dicen, 'Yo quiero que mi hijo crezca pa' que se vaya de la casa y eso' y uno lo quisiera como siempre tener los hijos con uno y eso. Y todavía se casan y uno quiere los nietos y to'l mundo que quiere que este reunido en la familia, somos la familia muy unidas.*

We care for our children, our parents, everyone, very much; we want to be always united... Because I have heard many people who say, 'I want my child to grow up so that they will leave that house and that' and one would like for them to like always have your children with you and that. And still they get married and one would like one's grandchildren and everyone, one wants for everyone to join together in the family, we are very united families.

Inherent in this description is the comparison to other cultures where individual needs are prioritized over group needs, namely the family's need to remain united. Laura further explained the difficulties and differences of raising children in the U.S., and the disruption and role reversal it caused among the family members.

*...uno no lo puede decir nada a los hijos, los hijos se crían que cuando viene a ver si uno se deja le dan golpe a uno, hacen lo que le da la gana... Eso es una cosa y un desastre, y y aquí no hay niños y los hijos son los padres, como quien dice. Ellos no obedecen, ni na'. En nuestros países no, los hijos, todavía yo vieja obedecía a mi mamá y mi papá.*

...One cannot say anything to one's children. Children [here] raise themselves and the next thing you know if you let them they'll hit you, they do whatever they want... That's one thing, and a disaster, and and and, here there are no children, and children are the parents, so to speak. They don't obey or nothin'. In our countries, the children, even as an adult I obeyed my mother and my father.

Thus the participants in the focus groups had a clear sense of what family meant to them as Latinos, and how these general beliefs and mode of identification was challenged by the reality of raising children in this country. The selected quotes highlight the core issue of respect as part of the Latino family dynamic. In addition, they remind the reader that as immigrants, the families must face and learn to cope with certain challenges to their cultural expectations. These challenges and pressures were related, in some cases, to experiences of depression and affected the way some participants viewed their treatment options.

The most obvious way in which the value of family unity was presented with regard to participants' experiences of depression was through descriptions of family ties, functioning and caretaking. That is, many participants described the importance of their role in the family, and

the expectations inherent in those roles, as a treatment supportive influences. One can get a sense of this aspect of the importance of family unity from the statements just described, yet they truly become alive and explicit in the quotations presented below. Pablo, a Mexican male in his mid-20s, described how he was struggling both with depression and with a drug addiction but was able to find the strength to seek treatment in order to function better for his family.

*A mi lo que me motivo fue mi familia, porque mi familia ahorita no esta conmigo pero ya va a venir mi hija y mi esposa. Entonces yo, yo, mi problema fue que yo no quería hablar con nadie y yo no le tenia confianza a nadie y fue lo que me motivo a tomarla, el querer estar bien para cuando viniera mi hija y mi familia. Porque yo hasta estaba delgado, yo no quería comer, y mis movimientos eran lentos y lo que me motivo a cambiar fue mi familia.*

What motivated me was my family, because my family right now is not with me but soon my daughter and my wife will come. So then I, I, my problem was that I did not want to talk with anyone and I did not trust anyone, and what motivated me to take them [the antidepressants], wanting to be well for when my wife and my family came. Because I was even thin, I did not want to eat, and my movements were slow, and what motivated me to change was my family.

In addition to not wanting to burden his family, Pablo also found the need to “be ok” before his family arrived to be a huge motivator in seeking treatment. Here one can again see the influence of immigration on an individual’s depression, namely that the importance of family reunification and the cultural value of family functioning can serve as a catalyst for an individual to seek out treatment. One can also argue that this quotation points to the reality that being here alone, without your family, can lead to depression. Valeria agreed with Pablo, stating that the need to function in order to fulfill her role as caretaker in the family led her to get help. She described the desire to function and take care of her children as the motivator for seeking treatment for her depression.

*Yo con el problema que tuve no podía, no funcionaba y entonces tenía que tratar de funcionar porque tenía por quien vivir, ocho hijos.*

Me, with the problem that I had I could not, I did not function and then I had to try to function because I had who to live for, eight children.

Similarly, Laura, the Dominican woman in her late 40s stated:

*Quiero estar arropada así, no pensar en nada pero los problemas y las, las obligaciones hace que uno se pare de ahí, los hijos. Yo creo que si no tuviera a mis hijos, yo no sé.*

I want to be wrapped up like this [i.e. with a blanket], not thinking of anything but the problems and the, the obligations make one get up from there, the children. I think that if I didn't have my children, I don't know.

Here again the combination of gender role expectations where women are the primary caretakers of children and the combined value of family unity led to Valeria's increased effort to seek help for her depressive state and Laura's motivation to take action.

Gladys' experiences were a bit more severe, she is a Mexican woman in her early 40s and spoke to us about her three children, one of whom had severe developmental disabilities. She was in such a state of deep depression that she would often stay in bed, unable to get up to take care of her children, much less her son with special needs. In the context of describing what motivated her to seek help, she described one day noticing that her younger children had assumed the responsibility of feeding and bathing their older, handicapped brother, a moment that somewhat shocked her into action.

*Tengo tres hijos que el mayor tiene, acaba de cumplir 18 años pero es deshabilitado. Lo que sé es que mi niño aparenta menos de la edad que la que tiene, no habla, escucha bien, entiende todo pero no habla, no camina así como debe caminar. Entonces mis otros dos hijos tienen 13 años y 11 años, y el ver que la responsabilidad que yo tenía con mi niño deshabilitado que lo estaba cargando mi niño chico, el ver que eran ellos los que ya me lo estaban bañando o dando de comer porque yo pasaba llorando, tirada en la cama, eso fue lo que me hizo a mí...claro, que era yo la que tenía que hacerme responsable de mi hijo y dejar que mis otros dos hijos tengan su niñez.*

I have three children and the oldest is, just turned 18 but he is handicapped. What it is, is that my boy appears to be less than his age, he doesn't speak, he listens well, he understands everything but he doesn't speak, he doesn't walk like he should walk. Then my other two children are 13 and 11 years old, and to see that the responsibility that I had

with my handicapped boy my youngest boy was taking on, to see that it was they who were already bathing him and feeding him because I spent my time crying, lying in bed, that was what made me... Of course, it was I who needed to make myself responsible for my son and let my two other children have their childhood.

Once again we can see how the responsibilities and pride that are invoked by the value of familismo can prompt people into action. Through this and the above examples, one can see the positive catalytic effects of the multiple facets of familismo.

Although for several cases the idea of caretaking and family responsibilities led participants to seek help, for some the responsibilities of caretaking and protecting the family were associated with depression. Gloria, a woman in her mid 50s from the metro area in Puerto Rico, described how the responsibilities of taking care of her children added to her level of stress to the point where she believed that she would never be able to get over her depressed state.

*Como yo tengo, como yo soy una mama muy apegada a mis hijas y cada uno de ella tiene su problemas, pues y yo pues me depri - nunca se me va acabar porque imagínate. Como madre nunca se me va a terminar el problema y entonces me preocupo por cada una de ella, ve, porque eso es como, como es... Mis hijas son las que me importan.*

Since I have, since I am a mother who is very close to my daughters and each one of them has her problems, well then I, well my depre [depression] – it is never going to end because, imagine. As a mother my problems are never going to end and then I worry for each and everyone one of them, you see, because it's like, how it is... My daughters are the ones who are important to me.

Gloria had been dealing with depression for ten years at the time of the focus group, and had been taking antidepressant medications for the past eight years. However, she stated that she did not see the possibility of full recovery because she associated her depression to her responsibility as a mother. The constant caring and worrying for her children that was involved in parenting was something that would never end, as she said.

Alberto, a Nicaraguan male in his late 50s, also associated family responsibilities with his depression. He described how he worked in a factory almost every day of the week for very long

hours, and how at one point he realized that something had changed.

*Yo recuerdo cuando yo vivía con mi esposa y con mis hijos...yo tenía que trabajar porque tenía dos hijos y mi responsabilidad era mantener a mis hijos. Pero yo observaba algo, cuando yo estaba trabajando ahí, sabe, después que yo cumplía con mi trabajo yo empezaba a llorar ahí arriba en la maquina. A mi no me había golpeado nadie, a mi no me había maltratado mi esposa ni mi jefe, nada.*

I remember when I lived with my wife and my children...I had to work because I had two children and my responsibility was to maintain my children. But I noticed something, when I was working there, you know, after I finished my work I started crying up there on top of the machine. No one had hit me, I had not been mistreated by my wife nor my boss, nothing.

From the description of his depressive symptoms, notably the overwhelming feeling of sadness manifested in his desire to cry unprovoked, one can conclude that the mere pressure of having to work in order to meet his responsibilities as a father felt like a burden. Here we also get a glimpse into some more gender role dynamics where the pressures of the traditional role of the man as breadwinner and provider become overwhelming to the point of depression. It is interesting to note as well that Alberto's frustration and depression could be tied to his position as a factory worker, a position for which he was overqualified but had to settle for due to his status as an immigrant.

The stress related to the dimension of maintaining good family relationships as part of familismo were evident when Leonor, a Colombian woman in her mid 50s, described her disappointment in her relationship with her only daughter. Leonor's case was further complicated by the circumstances of her widowhood, as she reported that her husband had been kidnapped and presumably murdered. Here the added pressure of having a good relationship within the family, which in this case involved Leonor's only daughter, became a very big stressor in her life, to the point where she felt the only option available to her was to become estranged from her next of kin. Leonor felt that her inability to maintain a good mother-daughter

relationship, and the negative responses she received from other family members due to her "inability" contributed significantly to her depression.

*¡Dímelo a mí que no tengo ni solo una hija y mi hija es mi enemiga, es mi enemiga! Y yo digo, '¿Que he hecho yo en esta vida mas que ser buena mama?' porque fui muy buena mama, y a mí me toco luego sacar a mi hija adelante sola, porque yo toda la plata que teníamos lo pague para el rescate de mi esposo, entonces me toco ponerme a trabajar durísimo, hacer muchísimas cosas para sacarla adelante, y que saque adelante lo peor que yo he podido sacar y es mi hija, y es terrible decirlo. Pero, es una persona que yo me pongo a pensar, '¿De dónde saco esa niña tantas cosas de su corazón tan malas para ser así conmigo?' y yo no la puedo entender.*

Tell me about it, that I have only one daughter and she is my enemy, *my enemy!* And I say, 'What more have I done in this life other than be a good mother?' because I was a very good mother, and I had to raise my daughter alone, because all of the money that we had I used it to pay my husband's ransom, and I had to work very hard, had to do many things to raise my daughter, and that what I helped raise was the worst thing that I could've given of myself and it's my daughter, it's awful to say it. But, she is the type of person that I think to myself, 'Where did that girl get so many bad things in her heart to treat me this way?' and I cannot understand her.

Leonor struggled with her identity as a Latina mother and questioned where she had failed in this arena, leading to an endless net of negative assumptions and guilt that perpetuated her depressive state. Of course, there were some clear unresolved grief issues surrounding the kidnapping and murder of her husband that contributed to her depression as well, yet the focus of this quotation is to describe how her strained relationship with her daughter triggered many of the negative thoughts and guilt feelings that made her feel worthless as a mother.

In addition to the idea of being together and valuing family unity, there is a sense in Latino culture that one must protect one's family. This may mean not sharing the pain or hurt that one is going through, especially with emotional pain such as experienced with depression. This aspect of familismo, which refers to maintaining an emotional safety net or positive emotional valence within the family, was described by several women in our focus groups. In the next examples, the discussion was taking place around what it was like to talk to their

therapist about their depression. During this discussion several focus group members volunteered information describing the practice of maintaining family harmony by withholding their negative emotional experiences. Valeria, a Puerto Rican woman in her early 60s stated,

*... es preferible uno hablar esas cosas con un particular que con la misma familia. Porque yo hablo mis problemas psiquiátricos y mis problemas cuando estoy bien nerviosa aquí en los grupos, con mi terapeuta [sic]. Con mis hijos yo no hablo nada de lo que siento...pero fijate, yo a veces me siento que seria bueno uno poder hablar con los hijos o con la familia y compartir el dolor que uno siente, pero al fin y al cabo lo que salen son problemas, mas problemas.*

... it is preferable for one to speak about those things with someone in particular than with your own family. Because I speak about my psychiatric problems and my problems when I am very nervous here in the groups, with my therapist. With my children I do not say anything about what I feel...but you know I sometimes feel it would be good to be able to speak with one's kids or with the family and share the pain that one feels, but in the end what you get are problems, more problems.

Here again, this speaker is describing the caretaking aspect of familismo that involves putting the needs of others before one's own. Not only is she bottling up her emotions, one might argue, but she is doing so to maintain a sense of stability and peace within her family. Perhaps too she is seeking to maintain some hierarchical structure by appearing to be happier than she might be in order to keep her children's respect.

Marisa, a Puerto Rican woman in her early 40s, pointed out that it is in one's own best interest to keep specific information about one's depression from the family. Speaking from her own experiences, she stated:

*La familia no es la mejor pa' uno expresar sus problemas porque a la larga siempre se lo sacan en cara a uno.*

The family is not the best [forum] for one to express one's problems because in the end they always end up throwing it in one's face.

Her concern here was the stigma and criticism that she may receive from family members if she were to truly express the depth of her depression or the intensity of her anguish.

Offering a slightly different perspective, Pablo, a Mexican male in his mid 20s, went on to say that not only is it better to hold back experiences and the negative emotions associated with depression, but that it is best to withhold that information for the good of the family.

*Yo no comparto con mi familia mis problemas porque no quiero molestarlos o envolverlos también en los míos, es mejor que yo lo haga con el terapeuta que cuando ellos me preguntan que como estoy yo les digo que bien o que a veces me siento triste para no preocuparlos y ya todo lo que siento lo cuento la doctora, o con la psiquiatra o con el terapeuta [sic], con el terapeuta.*

I do not share with my family my problems because I do not want to bother them or involve them in mine [my problems], it is better that I do that with the therapist, that when they ask me how I am doing I tell them that I am fine or that sometimes I feel sad so that I do not worry them and then everything that I feel I tell the doctor, or with the psychiatrist or with the therapist, with the therapist.

He is clearly describing the need to protect the family in the sense that he does not want to worry them or burden them with his problems. One can see from these quotations that participants were plainly stating aspects of familismo with which they identified and were proud of as part of their cultural backgrounds. Participants expressed that these were commonly held beliefs across Latino groups, gender, and ages.

The quotations from the focus groups emphasize that the concept of familismo is highly variably as was reflected by many participants and in several contexts. These results emphasize the complex nature of this cultural construct and highlight the fact that a particular idea such as familismo can create both treatment supportive and treatment discouraging pressures. In particular, the general value placed on family was seen most often as a motivator to seek treatment for their depression, though in some instances it was felt as a trigger for depressive symptoms. While the social contexts in which individuals find themselves vary, the Latino community members in our focus groups shared the experience of being immigrants and dealing with acculturation, apart from their diagnosis of depression.

This study was designed to expand the knowledge base regarding Latinos' experiences with antidepressant treatment. Focus groups were conducted to explore and record the perspectives of Latino community members regarding their personal experiences with depression and its treatment. Several aspects about familismo emerged through the focus groups that supported, contradicted, and highlighted the current literature on cultural concepts among Latinos in important ways. This article summarizes these results and makes recommendations regarding the implications of our findings for future research and clinical work.

## Discussion

### *Cultural Considerations.*

Culture is important when considering the experiences of depression among Latinos. These data support the construct of familismo and highlights the ways in which this value is a dynamic concept. Familismo arose as a cultural value representing family unity, respect and responsibility that created both treatment encouraging and treatment discouraging pressures for participants. Participants took pride in this cultural value and it was a prominent aspect of their identities as Latinos. In addition, they identified this as a value they felt was common to all Latinos. Thus the results from this study offer support for the claim made by Villareal and colleagues (2005) that familismo is a core aspect of Latinos in the U.S. In addition, our results provide further support for the finding by Geertzen and colleagues (1975; p. 234) that “sub-cultural beliefs and practices... are the underlying factors in seeking medical care. Within this general framework, knowledge of disease and family authority-tradition enter the picture as key intervening factors in health care utilization.”

Our data highlighted the ways in which family unity and family caretaking influenced participants' ability and motivation to recognize their symptoms as problematic, to seek

treatment, and to adhere (or not) to treatment. This lends support to the conclusions drawn by Jenkins (1988) that family importance influences health care seeking processes as well as treatment. The data presented herein supports the attitudinal aspects of familismo consistent with Villareal et al's work (2005). Participants spoke about family loyalty, respect, and reciprocity. The quotations on the importance of family caretaking also support the notion of attitudinal familismo. Our data also offer support for the relationship between *respeto* and familism and the importance of the family hierarchy (Garcia-Preto, 2005).

Despite this sense of universality, participants experienced familismo in various ways. Yet our data show help to show the nuances of the *experience* of such attitudes among Latinos who are struggling with depression, and further highlight the complex ways in which familism can influence the understanding, acceptance, and motivation to seek treatment for depression. The fact that we found important differences among participants in our sample points to the need to better understand the nuanced differences in the way family influences treatment seeking behavior and treatment adherence. Though notably working with different target psychological outcomes, our data contradict the results found by Hosch et al (1995) that family involvement increased medication adherence among Latinos with schizophrenia. This may be explained by the general acceptance and understanding of schizophrenia as a mental illness as compared to depression.

On one hand, some participants believed that certain aspects associated with familismo, such as the importance of the parenting role, motivated them to seek treatment so that they would better be able to function and perform in their family roles. In their study of Mexican migrant farm workers, Parra-Cardona and colleagues (2006) also found that participants' decision-making processes often revolved around family dynamics.

On the other hand, some participants experienced these responsibilities as burdens and triggers for their depression. Some found that in order to maintain a positive feeling among family members and not burden them, they had to cover up the degree of their depressed states. This particular aspect of familismo, the fact that certain things need to be kept from family members, is an important aspect when identifying benefits of counseling. Not only was this found to be true in this study, but also in the study by Karasz & Watkins (2006), where they identified conceptual models of treatment for depressed Latinos.

With regards to the understanding of familismo, this study demonstrates that this cultural value is a complex construct that has multiple facets, as had already been shown in the literature. However, this study adds to the understanding of the construct, “subjugation of self for family,” that was described by Lugo Steidel & Contreras (2003). The results of this study provide further evidence for this underlying construct and move the understanding of this construct beyond the basic value of respect for elders and providing instrumental support. In fact our findings suggest that there is a clear aspect of familismo that becomes a treatment discouraging influence on a Latino’s mental health status, in the case of our participants, seen as triggering or worsening depressive symptoms.

### *Research Implications*

Future research should continue to explore the ways in which cultural values influence attitudes towards, acceptance of, and experiences with antidepressant treatment. While these exploratory data support certain cultural constructs, such as *familismo*, they also highlight that each construct is a complex concept with a continuum of possible influences. Future studies may benefit from running multiple focus groups with family members of depressed relatives as well as focus groups with people who were offered antidepressant treatment but refused to take

them. In addition, quantitative research needs to be done to obtain more data that can be generalized. Specifically, quantitative methods can be used to determine factor analyses that would help further define the various aspects of familismo. For example, such studies can help distinguish between the ways in which familismo can motivate patients to seek treatment or be experienced as a precursor or added stressor for depression. Work such as that completed by Villarreal et al. (2005) is particularly useful in this area. In their study, the authors studied the psychometric properties of an attitudinal familism scale using a nationally representative sample. They found that familism can be measured in the same way across the U.S., Mexico, and Latin America. The work by Lugo Steidel & Contreras (2003) is also useful in the area of further teasing out the concept of familismo. Based on the results of our study, future research should aim to bolster the concept of “subjugation of self for family” by adding other questions that aim to understand how family ties and familismo can provide treatment encouraging and treatment discouraging influences for Latinos with mental illness. Studies such as these establish cultural values as aspects to be considered when performing culturally sensitive research.

### *Clinical Implications*

The data provide several helpful guidelines for clinical work with depressed Latinos. Overall, this study highlights the need for clinicians to be aware of the phrases that depressed Latinos use when describing their experiences. This can help providers better understand these concepts and ask more specific questions regarding Latinos’ experiences and concerns. The role of the therapist is to create an environment where a full range of emotions can be expressed and maintained. In addition to individual treatment, providers should consider the role of group therapy, as the focus groups themselves seemed to be therapeutic to many participants. The

concept of group work should be introduced to clients based on their level of acculturation, as recent immigrants are less likely to be open to sharing their personal experiences with strangers.

Clinicians should welcome significant others in treatment planning sessions. To find out if this would be helpful to them or not, it is important to first ask clients about family proximity and involvement. Family members can be both a source of strength and motivation for treatment and a source of stress and potential burden. This topic must be brought up in a way that allows Latinos the space to talk about the ways their families help and do not help. Many may not get a chance to voice the negative aspects of family involvement in other realms of their lives due to the pressure of familismo. Clinicians should work with family members to help them identify ways in which they enable the client to remain in their depressed state. They should also help identify ways family members can encourage the client to become active in treatment, taking responsibility for help seeking and adhering to recommended treatments.

One must keep in mind the complex nature of familismo, however. Clinicians must be careful not to dichotomize the concept into an either/or issue regarding its value, utility and relevance to treatment. For most Latinos, nuclear and extended family networks can be both a source of support and a source of stress, thus familismo can be simultaneously both a positive and a negative influence as it pertains to the experience of depression. However, due to cultural pressures, Latinos may not feel comfortable discussing the negative pressures of familismo and may feel guilty for having such thoughts. Clinicians should be aware of this complexity and try to create a nonjudgmental environment where Latinos can share the full range of their experiences regarding familismo.

Table 1  
Demographic Characteristics of Sample

<b>6 Focus Groups, N = 30</b>	
<b>Gender (% female)</b>	80
<b>Age (avg)</b>	27-66 (47 yrs)
<b>Time in U.S. (avg)</b>	1-40 (18 yrs)
<b>Years with MDD diagnosis (avg)</b>	5 months – 30 yrs (11 yrs)
<b>Years on Antidepressants (avg)</b>	6 months – 24 yrs (9 yrs)
<b>Country of Origin (%)</b>	
Puerto Rico	15 (50)
Dominican Republic	7 (23)
Mexico	5 (17)
Other	3 (10)
<b>Education (%)</b>	
< High School	13 (43)
Completed High School	9 (30)
Some College	6 (20)
College	2 (7)
<b>Spanish Language Literacy (%)</b>	
Not too well/Illiterate	6 (20)
Fairly Well	3 (10)
Very Well	21 (70)
<b>English Language Fluency (%)</b>	
Not too well/Can't speak	25 (83)
Fairly Well	4 (14)
Very Well	1 (3)
<b>Language spoken with Family (%)</b>	
Mostly Spanish	22 (73)
Spanish and English	7 (23)
Mostly English	1 (4)
<b>Language spoken with Friends (%)</b>	
Mostly Spanish	19 (63)
Spanish and English	8 (27)
Mostly English	3 (10)

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## APPENDIX A

### Focus Group Guideline

1. *¿Cual es su nombre? ¿De donde es? ¿Cuantos años tiene en los EE.UU.?*  
What is your name? Where are you from? How long have you been living in the U.S.?
2. *Vamos a enfocar la conversación en lo que es ser una persona Hispana o Latina. ¿Para usted, cual es la cosa más importante de ser una persona Hispana o Latina? Si usted esta hablando con una persona de otra cultura, ¿que le diría que son las cosas más importantes de ser una persona Hispana o Latina? Escriba las 3 cosas más importantes para usted.*  
Let's focus the conversation on what it is to be Hispanic or Latino/a. For you, what is the most important thing about being Hispanic/Latino? If you were speaking to someone from a different culture, what would you tell them that the most important things are about being Hispanic/Latino? Write down the 3 most important things for you.
3. *Piensen por un momento en personas que han conocido que han tomado la medicina antidepressiva. ¿Que habían oído sobre las experiencias de esas personas?*  
Think for a momento n people you have known who have taken antidepressant medications. What had you heard about other peoples' experiences?  
\*\*elicit positive and negative\*\*
4. *¿Ustedes piensan que es diferente para los hispanos tomar la medicina antidepressiva? ¿De que forma?*  
Do you think taking antidepressant medication is different for Hispanics? In what way?
5. *Piense en la primera vez que su doctor le sugirió tomar medicina para la depresión. ¿Que pensaron en ese momento? ¿Que representa para usted tener que tomar medicina para la depresión?*  
Think about the first time your doctor suggested that you take medication for your depression. What did you think at that moment? What does taking medication for your depression represent to you?
6. *¿Que fue lo que le motivó para tratar la medicina antidepressiva?*  
What motivated you to try antidepressant medications?
7. *Piense en ocasiones cuando usted no quiso tomar su medicina. ¿Por que razones no ha querido tomar su medicina antidepressiva?*  
Think about times that you did not want to take your medicine. What were some of the reasons you had for not wanting to take your antidepressant medication?
8. *Hay veces uno intenta y quiere tomar la medicina pero por varias razones se le complica y uno no llega a tomárselas. ¿Cuales complicaciones le han impedido poder tomar la medicina para la depresión?*

There are times when one tries and wants to take the medicine but for various reasons it gets complicated and one cannot take them. What complications have impeded your being able to take your antidepressant medication?

**\*\*cues: Money, forgetting, influence of others\*\***

9. *Muchas veces uno tiene que decirle cosas importantes sobre la medicina al psiquiatra. Quizás uno tiene que decirle que la medicina no está ayudando o que le ha causado efectos secundarios. ¿Cómo se sienten ustedes cuando hablan con su doctor sobre estas cosas?*

Oftentimes one has to tell one's psychiatrist important things about the medication. Perhaps one has to tell him/her that the medication is not helping or that it is causing side effects. How do you feel when you speak to your doctor about these things?

**\*\*\*elicit positive and negative experiences\*\*\***

**\*\*\*cues: pena (shame), miedo (fear), piensan que su doctor le escucha (do you think your doctor listens)\*\*\***

10. *¿En qué forma le ha ayudado la familia en tomar sus medicinas?*

In what ways has your family helped you in taking your medications?

11. *¿Cuáles son cosas que su familia ha hecho que NO le han ayudado con las medicinas?*

What are some of the things your family has done that have NOT helped you with the medications?

12. *Ustedes han reportado hoy cosas que son difíciles sobre tomar la medicina antidepresiva (list examples). Ustedes también han descrito cosas que les han motivado para tomar su medicina (list examples). ¿En la final, qué es lo más importante en decidir cómo tomar su medicina?*

Today you have reported things that are difficult about taking antidepressants (list examples). You have also described things that have motivated you to take your medications (list examples). In the end, what is the most important thing in deciding how to take your medication?

## APPENDIX B

### Code Manual

#### **Cultural Considerations**

*Alegres (Cheerful)* 11 instances, 6 people, 20%

Refers to participants mentioning cheerfulness as a character trait shared among Latinos and includes the general importance of laughing, dancing, singing, joking, etc among Latinos. For example: “We are very cheerful people, yes, even if there is no money, no matter what, we are [cheerful].”

*Americanos (Americans)* 20 instances, 11 people, 37%

References made by participants regarding the similarities or differences among Latinos/Latino culture and Americans/lifestyle in the U.S.A. For example, “Here everything is too fast, and money, and this, and work. For example in my country things are smoother, people don’t worry so much. You eat and you sit and if you don’t have meat you eat a piece of platano and you’re happy. But here you have one house and you want two, and it’s money and money and money...”

*Ayudar/Compartir/Dar la mano/Serviciales (Help/Share/Lend a hand/Service oriented)* 26 instances, 14 people, 47%

Refers to the general value of being helpful and giving towards others. For example: “I feel proud to be Latina because in the time that I’ve been here I have always lent a hand to everyone without expecting anything in return.”

*Cariñosos (Affectionate/Loving)* 5 instances, 6 people, 20%

Refers to the general value of being affectionate towards others. For example: “I think that Hispanics are very loving, especially with family, we always want to be together.”

*Cultural pride* 14 instances, 14 people, 47%

References to feelings of pride related to being of a certain area, country or group. For example: “I’m very happy to be Puerto Rican, of speaking the language, and having Puerto Rican friends.”

*Desahogo (Relief/Unburden oneself)* 13 instances, 7 people, 23%

This code includes indications of feelings of relief or unburdening oneself. Since the term also implies that there is a build up because there are certain things that you can't say with some people, statements describing the difficulty of expressing oneself with family are coded with this. For example; "Well there you express with your psychiatrist or your psychologist whatever, everything that you have inside, because it's only between you and her, not between anyone else, and then you have a relief in your soul, expressing to that person *everything* that you feel inside, you get it out."

*Discrimination* 6 instances, 3 people, 10 %

This code captures instances when participants spoke about experiences with discrimination. For example: "Well here it's like the Americans like look down on, they make Hispanics seem like they are below them."

*Educación mas fuerte (More rigorous schooling)* 2 instances, 2 people, 7%

This code was created to capture statements when the speaker identified a more rigorous schooling in their home countries compared to the schooling received by their children on the U.S. Mainland or in Puerto Rico. For example: "Well in terms of our culture, we know, we make it our business to see everything that our country represents, every city, every place, and in terms of education, I don't know, I see that we Latinos have more rigorous schooling than the educations that people from other parts have, and I've had the opportunity to live here, in Spain and I've traveled through Europe and all that, and I notice."

*Educación moral/tabú (Moral education/taboo)* 7 instances, 8 people, 27%

Here we captured references to values of respect and other traditional values of behavior and interpersonal relations, such as: "Well I've found that in this day and age the way to raise children...is very different from my times. You know in my times there was *a lot* of respect for everybody, a lot of education, a lot of education."

*Familismo (Familism)* 50 instances, 21 people, 70%

With this code we tried to capture statements that referred to a strong family orientation, including the ideas that networks within the family are emphasized over non-family networks, that individual needs are subsumed under family needs, that there is a strong weight given to issues of family, respect, functioning, caretaking, providing, etc. For example, "I couldn't deal with the problem that I had, I wasn't functioning. I wasn't functioning but then I had to try to function because I had a reason to live, my 8 children." We also included statements that showed that the speaker did not want to burden their families with their problems, at their own expense, which differs from not talking to family members due to their lack of understanding of the problem or due to fear of stigma. Finally, we also included examples that run counter to the idea of *familismo* because they illustrate the complexity of the construct. For example, "There're just some things you can't talk to family about" tells us about familismo and its boundaries.

*Folk healer/alternative medicines* 6 instances, 5 people, 17%

We used this code for all references to alternative medicine or the use of folk healers as a treatment method for depression. We included statements such as: "I don't work so I don't have any colleagues/friend, I'm dedicated to my home and nothing else, and well, I've been feeling better for the moment, but the pills, I think, I don't know. But I am sure that when I was in Mexico and I was being seen by an *espiritista* (spiritist) I saw results there."

*Food* 6 instances, 5 people, 17%

This code was used to capture instances where participants mentioned food as an important aspect of their heritage. For example: "I feel proud to be Hispanic because of my culture, it is different from Americans. Also for the food..."

*Honesta (Honest)* 2 instances, 2 people, 7%

This code refers to the value placed in honesty, such as, "Be honest with everyone."

*Iguales en la depresión (The same in depression)* 15 instances, 10 people, 33%

Refers to statements made by participants that compare the experiences of Latinos with depression to those of other groups with depression. These statements can speak about personal experiences or ideas regarding the experiences of a group as a whole. For example, "I don't exactly know because I haven't been in a group of other people that aren't like us, Latinos, but I think we all feel the same thing, that darkness, that fear, that desire to not even have to bathe, not have to get up, not eat, of losing 4 or 5 pounds or gaining them, you know."

*Language/Hablar español (speak Spanish)* 11 instances, 9 people, 30%

With this code we captured issues of language including cultural pride, such as, "I am proud to be able to speak Spanish" as well as language barriers or stressors, for example, "It causes a little depression when you can't express yourself, you go somewhere and you don't know how to relate to others because you don't speak their language."

*Migration* 10 instances, 11 people, 37%

This code refers to the multitude of variables that are related to migration, such as unique issues (e.g., separation of family), satisfaction with migration, reasons for migrating, etc. For example, “But the reason that I came here was for that, seeking help.”

*Pan-ethnic identity* 6 instances, 7 people, 23%

Any indication that the speaker identified as Latino as whole, versus unique Latino nationalities (e.g., Puerto Rican, Mexico, etc) was included in this code. Since questions were framed as "Latino" or "Hispano" we looked for evidence that the speaker was thinking collectively as Latino, not just responding to the question's frame. For example, “Different cultures from different countries, right, but I think we are all united by God.”

*Poner de su parte (Do one's part)* 23 instances, 13 people, 43%

Statements that capture the general value that one must do one's part in order to get better. This code should include statements such as, “I think that if we really love ourselves it's important to not just let the medicine, not just leave our problems in the hands of the medicine, I think we also need to help ourselves and find ways of entertaining/distracting ourselves. If you can't work, you can still very well do crafts at home or something...”

*Religion* 24 instances, 14 people, 47%

Statements that make reference to a religious or spiritual belief, such as, “But also when you come from a religion, I am evangelical, and well supposedly they teach you in the church that God can cure you and that you don't need to be taking so many medicines...”

*Sociocultural explanations* 24 instances, 12 people, 40%

Any statements that provide an alternate explanation for depression based on a particular social or cultural point of view. For example, “...but then came the economic problems, the problems with my children, alone in this country, fighting for them and sometimes that doesn't let you get out... because when you have a lot of problems you get depression.”

*Trabajar, luchar, aprovechar (Work, fight, take advantage)* 29 instances, 18 people, 60%

General values regarding working hard, fighting for your dreams/values, and taking advantage of opportunities in this country. For example, “We can't afford the luxury of saying, ‘Today I'm not going to work’ or to think that the government is going to maintain us, no. We have to work crying, suffering, no matter what we have to be at work.”

*Unidos (United)* 11 instances, 9 people, 30%

This includes statements that reflect the general value of unity amongst Latinos. For example, “We are very generous and very united.”

### **Common concerns**

*Fears* 108 instances, 28 people, 93%

This is a supercode that was created to combine “addiction/atado al medicamento,” “medicina por vida,” “miedo al daño,” and “muchos medicamentos.” Then we unlinked instances where the quote did not capture a sense of fear. Sample quotations are given for each individual code under this supercode.

*Addiction/“Atada al medicamento” (Tied to the medication)/“Una droga” (A drug)*  
30 instances, 14 people, 47%

This code refers to the fear of being addicted or attached to the medications and implies that the long term use of a medication is due to dependence or being stuck with it. It includes quotations such as: “Those are drugs, when you take them, the day you stop taking them... no, you’ll be tied to those medications because that’s the only thing that is going to work for you.”

*Medicina por vida (Medicine for life)* 25 instances, 13 people, 43%

This was meant to include the basic idea of having to take medicines for life or for a long time and to illustrate the dimensionality of this concept, we included quotations were speakers described being ok with the idea of being on medicines for life. One example is, “...the medicine you have to take for the rest of your life! Because already that, that imbalance in your brain, how do you call it, is not going to get better without the medicine. That worries me a lot, once they put you on medicine (smacks fist into hand), with that medicine for many years, right, you stay on that medicine for a long time.”

*Negative influence of medicina por vida* 10 instances, 4 people, 13%

This code was created to highlight the ways in which *medicina por vida* was seen as a negative influence for attitudes toward depression.

*Miedo al daño (Fear of harm)* 35 instances, 16 people, 53%

This is a code that refers to the fear, anxiety, and apprehension to a medication's potential negative effects or side effects, but it does not include fear of addiction (which is captured under another code). We also included people’s explanations for being ok with

the negative effects or side effects. For example, “Well because, one doesn’t, one doesn’t have the desire to take them, or because one thinks it harms the liver.”

*Muchos medicamentos (Too many medications)* 24 instances, 15 people, 50%

Meant to capture the idea that speakers felt they had to take too many medications, this code tended to co-occur with various other codes. One example of a quotation with this code is, “Well because I was already tired of so many medications, I felt my stomach was very affected, then I started taking Mylanta and eating when I was going to take the medicines and I felt very tired....”

*Relapse/Caer en lo mismo* 27 instances, 15 people, 50%

This code can include actual relapse or the fear of relapse. One example would be, “Every time that I let a tear loose, I call my friend, ‘Look I’m in a depressive state,’ because I am terrified of it. Because I get so so bad/down that I am scared of having depression.” \*\* This code might also come up under the general topic of adherence issues.

*Side effects* 61 instances, 25 people, 83%

Direct expressions or explanations of the side effects experienced by the speaker, but does not include fear of side effects. One example would be, “The side effects made me feel really bad, they made me sleepy, I got nauseous, they give me headaches, oh no, they make me feel really bad!” \*\* This code might also come up under the general topic of adherence issues.

### **Adherence issues**

*Acceptance of Illness/Treatment* 64 instances, 24 people, 80%

This code captures explicit statements about participants’ reactions to accepting or denying treatment/illness. This code is meant to capture participants’ initial reactions and the unique process where the patient reacts to the new issues of depression and treatment. Since acceptance is a process that happens over time and often includes information obtained after the initial diagnosis/treatment recommendation, this code will also include statements that reflect this process. This will include quotations such as: “The problem is that people don’t want to take notice, they don’t want to admit that they are in a depressive state. They think, ‘No this is only momentary’ and they keep it to themselves...”

*Adherence examples* 51 instances, 18 people, 60%

This code captures explicit statements that reflect a participants' adherence with the medication. This code should include quotations such as: "I've always taken my medication, like going to church, it's a devotion."

*Awareness of depression* 75 instances, 27 people, 90%

The process of awareness related to their initial learning, not insights acquired during/after treatment (see Insight about depression). For example: "I only knew that depression was to cry and feel sad, but I didn't know it could be treated."

*Finding out about depression* 35 instances, 17 people, 57%

This code captures the process of awareness related to participants' initial learning about depression as an illness or upon first receiving their diagnosis. This code does not include insights acquired during or after treatment. For example, "I only knew that depression was to cry and be sad, but I did not know it could be treated."

*Insight* 19 instances, 14 people, 47%

Related to the above code, this code refers to the process of awareness after their initial reaction. For example, "When people tell me to stop taking the medicines, I ask why. They say because it's a drug. I tell them, no it is not a drug. I explain to them that I am taking it for my brain...it is a supplement I need for my brain because I have a low level of certain cells...that's how I convince them..."

*Learning/Ya me di cuenta* 23 instances, 12 people, 40%

This code captures statements regarding learning that has taken place regarding medications based on experience with the medication (for example with discontinuation). General learning is coded under "insight." One example quotation with this code is: "In the long run, if you stop your medication you fall back again, you fall again [into depression]."

*Decisional balance* 96 instances, 28 people, 93%

This code includes statements that reflect the speaker's ambivalence or the speaker's rationale for being adherent or nonadherent. This code does not include statements of adherence or nonadherence that do not have a rationale (these were captured under the codes Adherent or Nonadherent, as relevant). Statements such as the following should be included: "It's like you feel bad because you never want to feel sick, and taking the medication means that, that you're

sick. I don't really like the idea of having to take them for a year...but if it's going to help me I have to do it."

*Different people, different reactions* 9 instances, 9 people, 30%

The expressed understanding that medications do not work the same for every person, and that while some side effects might be present for some people, they may differ for others. This code should include statements such as; "Some people have side effects and others don't, because not everyone has the same system."

*Discontinuation* 28 instances, 17 people, 57%

This code is a part of nonadherence but is different in that it refers to getting off of the medication, not skipping doses. This code includes when the speaker indicates getting off of the medications, having symptoms get worse, and then getting back on. This code also includes verbalized intent to discontinue medications. One example of a statement with this code is: "I for example, one time spent three, four, five days without taking them to see what would happen to me. I fell into it [the depression] again, and what happened? I went to the doctor and I said, 'Doctor X, I need to use these for the rest of my life, for ever.'"

*Financial barriers* 16 instances, 8 people, 27%

This code captures when speakers address any financial difficulty related to treatment in general (i.e., affording meds, psychologist), we did not code for financial difficulties that were not related to affording/accessing treatment. For example: "Money. Money, sometimes I don't have the money to buy them...you have to work for a week to buy your medicines here. Leave people without food in the house (laughing) so you can buy your medicines!"

*Nonadherence examples* 78 instances, 25 people, 10%

This was a super code created from the following codes: discontinuation, nonadherence (for each coder), forgetting, and medication adjustment by self. This code was intended to capture all instances of nonadherence. Not all instances of forgetting to take medications qualified as nonadherence so AI went through those to unlink when appropriate. This code allowed us to later determine if any one particular code was related to nonadherence. This code should include quotations such as: "For me, I don't take them. I'm not too, you know, with taking them consecutively. When I feel very bad I go and I take two and three in a day. If it says one, I have days that I take two and three pills because I feel so bad...I know it's not good, the treatment isn't like that."

*Working the treatment* 250 instances, 28 people, 93%

This code is meant to be a very encompassing code used to capture what patients must do to work the treatment, after acceptance and before discontinuation. At first it was created using a supercode with: alliance with providers, benefit of treatment (including lack of) falta de deseo,

forgetting to take medications, medication adjustment by doctor or self, and rutina de medicina. Then, all instances of working the treatment were reviewed in order to unlink instances where it was not appropriate. Later, quotes coded as side-effects, stigma, family influence, social influence, and financial barriers were also reviewed. Sample quotes can be found under the individual codes that are subsumed under this supercode.

*Alliance with providers* 92 instances, 26 people, 87%

This code is meant to capture anything referring to the quality of the treatment alliance, whether positive or negative, and includes references to talking to providers about questions or concerns regarding treatment. For example: “I feel very comfortable. I come and I tell her that I feel very bad, that I’m gaining weight. I even brought a tea to her so she could check it to see if I could drink it, and she said I could drink it and not worry. I was so happy, and I thanked her.”

*Benefit of treatment, including lack of self efficacy* 101 instances, 30 people, 100%

This code is meant to capture anything that expresses whether or not treatment helps, specific to antidepressant medications. However, statements were not coded if it was clear that the speaker was not referring to antidepressant medications, if the speaker was only referring to the general idea that medicines help people, or if the speaker was referring to sleeping medications. For example: “The medicines have worked well for me, thank God, for now I feel more stable, I feel better, better than before.”

*Benefit of treatment, lack of* 24 instances, 15 people, 50%

This code captures only those instances where participants expressed a perceived lack of benefit of treatment. For example: “It’s happened to me that sometimes I take the pill and I still have the depression...”

*Falta de deseo/Lack of desire* 9 instances, 5 people, 17%

This code refers to an expressed decreased motivation to take medications due to worsened depressed mood. This includes simply not "teniendo ganas" (feeling like it) or symptoms interfering with taking medications, such as social isolation or being vegetative. An example would be, “When I am with the depression I don’t want to cook or do anything, not even take my medicine. I don’t want anything.”

*Forgetting to take medications* 28 instances, 13 people, 43%

This code includes not only forgetting to take medications, but also includes strategies that patients used to keep from forgetting, for example: “I don’t know if I took the pill or if I didn’t take it... so then the doctor gave me a pill box to put them in. That doesn’t work, though, because now I don’t know if I put the pills in there or if I didn’t. Sometimes some [compartments] are full and others are empty.”

*Medication adjustment – self* 6 instances, 6 people, 20%

This code refers to statements where the speakers shared ways in which they were changing their dosing on their own, for example, “I have one [medicine] that the doctor gave me, I take half of it at first, then the whole thing to see how I react to the pill.”

*Medication adjustment – doctor* 45 instances, 18 people, 60%

This code refers to statements where the speakers shared ways in which their doctors were changing their dosing or their medications, for example, “For me they changed them a few times, to find the one that would work for me, until they found it.”

*Rutina de la medicina (Routine of medication)* 28 instances, 12 people, 40%

This code encompasses direct expressions of the medicine becoming part of a daily ritual, such as, “Like eating a plate of food, that’s right, right there next to the plate.”

## **Other codes**

*Alcohol/Drugs* 10 instances, 6 people, 20%

This code is meant to capture references within statements regarding the use of alcohol or illicit drugs. This code is not the same as the code for Addiction/Drug because this refers specifically to the use of alcohol or marijuana, etc. For example: “What caused my depression was to see how I had my family, because of my addiction, how I had them so worried.”

*Family influence* 84 instances, 24 people, 80%

This code refers to the various ways in which family influences a patient’s views/behavior toward depression/treatment. Family values (i.e., familismo) are a part of this of this construct yet this one includes a wider range of influence. This code is not used when family is mentioned as a trigger for depression, because that is not an influence on illness perception/treatment, but rather a cause of depression. Statements such as the following are included in this code: “My brother, when he sees that I’m nervous the first thing he says to me is, ‘Did you take your pill? Take it, you’re nervous, I see that you’re not well!’.”

*Negative family influence* 24 instances, 11 people, 37%

This code specifically captures the way participants’ family members had a negative impact on their understanding of depression and treatment. For example: “...It was like my family didn’t understand me. It was like they thought that what I had was nothing, a joke.”

*Positive family influence* 41 instances, 18 people, 60%

This code specifically captures the way participants’ family members had a positive impact on their understanding of depression and treatment. For instance: “Well I feel very supported because my mom when I had a lot of problems that I couldn’t resolve on my own, my mom would counsel me to seek help.”

*Functioning* 8 instances, 6 people, 20%

Here we coded anything related to functioning that was not coded under interpersonal functioning, such as an inability to work or study. Quotations such as the following were included in this code: “When I went to the doctor, they realized that I had depression, without my asking them to give me disability, they gave me disability for 6 months, then they went again and gave me disability for 6 more months.”

*Gender* 4 instances, 3 people, 10%

This code captures statements that made clear references to gender differences in depression. For example, “Hispanic women, we look for help and we don’t give any importance to what she might say if I go to a clinic to get help for depression, but the Hispanic man, from our country, has this *machista* pride, they don’t seek help because of their pride.”

*General medical condition* 18 instances, 11 people, 37%

We coded instances where speakers mentioned concurring medical conditions other than depression, usually conditions that made their experiences more difficult, both with their depression and with their treatment. For example, “Then too it was accompanied by my thyroid problem, and that contributed more to my depression because I am a survivor of thyroid cancer, and I was low on my thyroid and they went up, thank God the medicine for the depression has been of great help to me.”

*Interpersonal functioning* 27 instances, 15 people, 50%

Captures real interpersonal dysfunction experienced by the speaker, not just others noticing/commenting that the speaker is sad. For example, “I totally isolate myself, when I’m depressed, I close the door to my room and I don’t come out, I isolate myself totally.”

*Social influence* 29 instances, 17 people, 57%

This code refers to the various ways in which friends or other social influences (media, word of mouth, etc), can affect a patient’s views/behavior toward depression/treatment. For example, “And another thing, when a medicine, um, you are taking, for example Zoloft, and they are saying on the television and everywhere that it causes a lot of harm, and you are taking it, you are taking it with a lot of fear.”

*Negative social influence* 24 instances, 14 people, 47%

This code specifically captures the negative ways that friends, neighbors, or other institutions influenced participants. One example would be, “I would not take them because I was scared, yes because people said that if I took that I would be in bed all day.”

*Positive social influence* 7 instances, 6 people, 20%

This code captures the positive ways that participants were influenced by their social environments. For example by feeling supported: “Every time that I drop a tear I call my friend.”

*Symptoms* 72 instances, 25 people, 83%

Any reference to the symptoms of depression experienced. For example, “I didn’t know it was depression, it was something that I was fighting with because yes, I would get up every day and say to myself, ‘Today I’m going to do this and that,’ I’d do half a turn and throw myself in the bed. I would get up again and I wanted to do something, and back into bed.”

*Somatic presentation/concerns* 12 instances, 9 people, 30%

Statements that make reference to somatic concerns or presentations, including sleep, appetite, weight, etc. For example, “In my case I start to lose weight, mine [my depression] affects me physically.”

*Stigma* 59 instances, 19 people, 63%

This complex code includes negative associations to medication, to the illness label, and/or to the treatment facility. The source of the associations can be the speaker him/herself or others. The negative association must be a misperception and can include crazy, weak, useless, unable to handle problems, losing against problems, or unable to function. For example, “I have a daughter who is 16 years old, and she says to me, ‘No Mom, I am not going to take that medicine because that’s a drug, and that’s for crazy people.’”

*Stigma with Addiction...* 86 instances, 22 instances, 73%

This was a supercode created to capture instances where stigma and addiction overlapped. See individual codes for sample quotes.

*Triggers* 54 instances, 21 people, 70%

Statements that describe triggers for depressive episodes, such as, “Well, sometimes the death of a family member can cause a depression, because I was so depressed when my father died of bone cancer...”