Aging Puerto Ricans’ Experiences of Depression Treatment: A New Ethnographic Exploration

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Aging Puerto Ricans’ Experiences of Depression Treatment: A New Ethnographic Exploration

Abstract

Purpose
To examine aging Puerto Ricans’ experiences with and perceptions of depression treatment.

Methodology/approach
In-depth analysis of eight exemplary cases from ethnographic interviews with a subsample of 16 aging Puerto Ricans in the Boston area who are part of the Boston Puerto Rican Health Study.

Findings
The results show that respondents were resistant to accepting pharmacological treatment for their depression, and they often characterized antidepressants as “dope.” Moreover, they claimed that in addition to their health problems, social stressors such as financial strain, lack of jobs, housing problems, and social isolation are triggering or contributing to their depression. Because of this, they express reluctance in accepting clinical treatment only, and suggest that broader social issues and other health needs ought to be addressed as part of an effective treatment. For many, pharmacological treatment is acceptable only in the more severe forms of depression.

Research limitations/implications
These results have important implications for improving the quality of depression treatment and reducing health disparities for mainland Puerto Ricans.

Originality/value of chapter
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Aging Puerto Ricans’ Experiences of Depression Treatment

AGING PUERTO RICAN’S EXPERIENCES OF DEPRESSION TREATMENT: A NEW ETHNOGRAPHIC EXPLORATION

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Aging Puerto Ricans’ Experiences of Depression Treatment

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**Key words:** Puerto Ricans, Latinos/Hispanics, depression, mental health disparities, depression treatment
Aging Puerto Ricans’ Experiences of Depression Treatment

Introduction

The disproportionate prevalence of depression among aging Hispanics is well documented, particularly among Puerto Ricans who—among all Hispanic subgroups—exhibit the highest rates. Key social and medical factors are associated with the prevalence of depression for this U.S. population, these include: being female, having lower education levels, health problems and problems with access to medical care (Falcon, & Tucker 2000; Kemp, Staples, & Lopez-Aqueres 1987; Ramos, 2005; Robinson, Gruman, Gaztambide, & Blank, 2002; Rodríguez-Galán, & Falcon, 2009). According to a report by the Department of Health and Human Services published a decade ago, Hispanics in general and other older adults are less likely to receive depression treatment that meets the general quality treatment guidelines. In this regard, language barriers may impede access to specialty mental health care, especially because Spanish speaking mental health providers are underrepresented in those professions (DHHS 1999). These institutional barriers seem to still affect mental health treatment for Hispanics today. Moreover, personal and cultural barriers such as attitudes, social norms and beliefs regarding treatment for depression may prevent some from seeking help or adhering to treatment (Cooper et al.,2003; Keyes et al., 2012). Although several studies have addressed health disparities for Puerto Ricans, the general question of access to quality depression treatment, and especially the experiences with various types of treatment and their perceived effectiveness from the subject’s own point of view, have received little to none scholarly attention. Our study offers an exploratory investigation of this unresolved research issue.

The purpose of this paper is to investigate Puerto Rican’s experiences with treatment
Aging Puerto Ricans' Experiences of Depression Treatment

through the use of in-depth, semi-structured ethnographic interviews with a small sample of aging Puerto Ricans (age 50 and above) in the Boston area. In so doing, our aim was to offer a micro-level investigation of reported access to various treatment options and their perceived effectiveness. We hypothesized that a low socio-economic profile, cultural and language barriers, and the inadequacy of the mental health system and mental health policy in addressing Hispanics and the poor would hinder access to adequate treatment for depression.

Puerto Ricans represent the largest Hispanic group in Massachusetts and share similar characteristics with other Hispanic subgroups, such as language and other cultural similarities. However, they also possess their own socio-cultural idiosyncrasies, particularly due to their status as U.S. citizens and the historically uneasy relationship between the island of Puerto Rico and the U.S., which has resulted in a peculiar pattern of migratory flux to the mainland, including immigration, outmigration and circular migration (Baer, 1992; Borjas & Bratsberg, 1996). In this context, Massachusetts has been a secondary site of migration for aging Puerto Ricans, the majority of whom were born in the island. Because of the special legal status of Puerto Ricans and their unique migration experience, it will be necessary to situate our discussion within the larger context of the history of outpatient mental health policy in the United States, especially as it relates to treating both immigrant and minority populations.

As was the case of other minority immigrant populations in the past (see Vander Stoep & Link, 1998, for a discussion of the Irish) psychiatric epidemiological research on Puerto
Aging Puerto Ricans’ Experiences of Depression Treatment

Ricans has been plagued by ethnocentric biases in many instances. Not only have Hispanics in general been challenged in terms of gaining access to mental health services, but they have also had an often traumatic relationship with the mainstream of U.S. psychiatry and psychology, in large measure due to a lack of cultural understanding of this population, which has often lead to misdiagnosis and stigmatizing psychiatric labels such as the so called “Puerto Rican Syndrome.” This form of mental distress was first observed by U.S. psychiatrists in Puerto Rican soldiers who had been drafted in the island to fight during War World II (Gherovici, 2003).

Both mental illness and physical illness for that matter are now generally understood as a complex phenomenon involving the interplay of biological, environmental and socio-economic factors. Although popular misconceptions about the nature of “race” and “ethnicity” persist even among health researchers today (Baer et al. 2013), most social scientists now conceive race as a social construct, rather than a biological structure. Observed health disparities among minority groups, women and the poor are largely explained by social and economic factors in the research literature (Kuzawa & Sweet, 2009). Because of the social and economic basis for this excess of mental health issues in a community, Alegria and colleagues (2003) have further posited that not only mental health but also public policies in general play a crucial role in eliminating mental health disparities, which are driven by housing, education and income factors that affect U.S. minority groups disproportionally (Alegria, Perez, & Williams, 2003).

Recent epidemiological studies on mental health in Puerto Rican populations have used
Aging Puerto Ricans’ Experiences of Depression Treatment

the Center for Epidemiologic Studies Scale (CES-D) and the NIMH Diagnostic Interview Schedule (DIS) to assess symptoms of depression. The former has been proven a more valid measure of depression in Puerto Rican populations (Robinson, 2002). Using this scale, the Hispanic Health and Nutrition Examination Survey confirmed the higher prevalence of depression symptoms among Puerto Ricans compared to both Mexican Americans and Cuban Americans. Additionally, researchers found support for the social stress hypothesis, in other words, psychological distress among Puerto Ricans was associated with their higher rates of unemployment, lower income, and marital disruption when compared to Mexican-Americans or Cuban-Americans (Angel & Guarnaccia, 1989).

Another recent survey, the Massachusetts Hispanic Elders Study, examined the prevalence and correlates of depression of older Hispanics (Puerto Rican, Dominican and Other Hispanic origin) in the state and a comparison group of Non-Hispanic Whites. This study found higher rates of depression symptoms for Hispanics than ever reported, especially for Puerto Ricans. Depression for this Latino sub-group was associated with being female, living alone, and having a high number of health problems. In fact, chronic health conditions were the factors most consistently associated with depression in this Massachusetts sample (Falcon & Tucker, 2000). Moreover, Hispanics as a whole, and Puerto Ricans in particular, were more likely than Non-Hispanic Whites to experience problems with access to medical care. For Puerto Ricans being female, living alone, possessing low education levels, having high numbers of health problems, disability and access to medical care problems were all independently associated with depression.
Aging Puerto Ricans’ Experiences of Depression Treatment

symptoms (Rodríguez-Galán & Falcón, 2009). Thus, in addition to confirming the social stress hypothesis earlier reported by other researchers (Malzberg, 1956; Haberman, 1976; Krause & Carr, 1978), this Massachusetts study suggests that inequalities in health and health care access help explain most of the disparities in depression.

Not only do Puerto Ricans in Massachusetts exhibit higher rates of mental distress, but—like other minority groups—they also encounter disparities in treatment. However, in comparison to other states, Massachusetts has kept a better record on responding to the mental health needs of minorities. Dickey and colleagues (1989) used the state of Massachusetts as an example of a state whose Department of Mental Health had made efforts to address the needs of racial/ethnic minority patients in state hospitals and the community, by using existing data on homicide rate, families in poverty, female-headed households, income level, and adults and children who speak a language different from English to arrive at estimates of need (Dickey et al., 1989). More recent studies continue to show, though, that throughout the nation Hispanics experience disparities in access to mental health treatment in comparison to non-Hispanic whites, particularly poor Hispanics who are less likely to have access to Medicaid specialty services in Latino neighborhoods and also experience language barriers and cultural stigma in seeking help for mental health issues (Alegria et al., 2002).

Under-representation of Latinos in the mental health professions constitutes a major problem; especially given that psychosocial therapy necessitates that the clinician be attuned to the cultural and linguistic background of the client. According to a report by
Aging Puerto Ricans' Experiences of Depression Treatment

the Department of Health and Human Services, one of the main obstacles for mental health treatment for Latinos is finding Spanish-speaking providers (DHHS, 1999). Even though the number of Hispanic staff was relatively high in the CMHC, these workers were concentrated in sub-master's degree types of occupations (Dowell & Ciarlo, 1989; Rochefort, 1989). Furthermore, according to the American Psychological Association, Latinos represent only 1% of all practicing psychologists, whereas 96% of psychologists identify themselves as Whites (DHHS, 1999). Moreover, while the Latino population continues to grow, the numbers of Latinos receiving PhD degrees in psychology have remained stagnant at about two percent of all graduating students (Maton et al., 2006). It is also worth noting that not all self-identified Latinos are fluent in Spanish, a skill that would be necessary in order to offer treatment to the majority of today's older Hispanics seeking psychotherapy. The same report by the Department of Health and Human Services shows evidence from available community studies that point to the insufficient mental health care that Hispanics are receiving. In fact, Latinos were twice as likely to receive treatment for mental health in general health care centers rather than mental health specialized settings (DHHS, 1999). These general health care centers often lack specialized knowledge about the cultural and language differences of minority patients and generally do not reach out or advocate for older Hispanics (Biegel, Farkas, & Song, 1997). Interestingly, one study conducted in Puerto Rico, found that the use of mental health specialists was associated with a higher socioeconomic status, which supports the argument that economic barriers interfere with the use of mental health services in the US (Vera et al., 1991).
Literature on Treatment of Depressed Adult Hispanics

Older adults are, in general, less likely to receive adequate depression screening and treatment. While this holds true across all racial/ethnic groups, it is particularly prevalent among historically oppressed racial/ethnic groups (Olsson et al., 2002; Young et al., 2001). Yet, it has been found that older adults would be inclined to receive psychosocial services, in particular psycho-educational services and psycho-educational programming (Aeran et al., 2002). Some scholars have attributed under-treatment among depressed older adults to individual behaviors, such as stigma attached to mental disorders among the elders, as well as to failures in the mental health system. For example, the failure of health care providers to properly identify symptoms of depression in the older population and ageist beliefs among health professionals that impact how aging individuals are treated. General guidelines recommend that, in managing depression care for older adults, it is necessary to assess their health, living conditions and social isolation and require the intervention of other health and social agencies when appropriate (NICE, 2004).

The issue of what constitutes appropriate treatment for depression is in itself the subject of much controversy. In this regard, it is important to note that even though depression is used in this study as a general term, it is certainly a diverse phenomenon. There are different forms of depression, this illness can also be acute or chronic, and there is also a range of degrees of severity. For this reason, the particular kind of treatment/s may vary for each individual case. In general, mental health experts recommend that adequate treatment usually involves both biological therapy (i.e. pharmacotherapy or ECT) and
Aging Puerto Ricans’ Experiences of Depression Treatment

psychosocial therapy (i.e. cognitive behavioral therapy) (NICE, 2004). However, it is also believed that psychotherapy alone can be as effective as pharmacotherapy in alleviating symptoms in milder forms of depression (Olfson et al., 2002). Still, Hispanic elders are less likely to have received depression treatment that met the general depression guidelines, less likely to use antidepressants and more amenable to prefer psychosocial therapy over medication (Bazargan et al., 2005a; Cooper et al., 2003; Miranda & Cooper, 2004; Miranda et al. 2004; Olfson et al., 2002; Virmig et al. 2004).

Attitudes, beliefs and social norms may also play a part in acceptance of treatment (Cooper et al., 2003). Both psychotherapy and antidepressants have proven to be effective in treating depression (Brown and Schulberg 1998; Schulberg, Pilkonis and Houck 1998). However, Hispanics and African Americans are less likely to find antidepressants acceptable for treatment and more likely than Whites to believe that antidepressant medications are addictive and that counseling conjures negative feelings. Nonetheless, even though there are differences in beliefs about treatment modalities, these do not explain the differences in the acceptability of depression treatment (Cooper et al., 2003). Among Hispanics, socio-demographic characteristics such as the ability to speak English and the affordability of treatment have been associated with use of antidepressant medications among subjects diagnosed with depression by health practitioners. On the other hand, the use of alternative medicine has been associated with self-reported depression, financial strain and problems with accessibility and affordability of conventional medical care (Bazargan et al., 2005b).

Perhaps in large part due to the structural and attitudinal factors mentioned above,
Aging Puerto Ricans’ Experiences of Depression Treatment

Hispanics present disparities in access to outpatient mental health treatment compared to Whites. In fact, Latinos and African Americans are less likely to receive depression care than White patients (Bazargan et al., 2005b; Miranda and Cooper 2004; et al., 2002; Virmig et al. 2004). They are also less likely to take antidepressant medications or attend specialty mental health care than Whites (Miranda and Cooper 2004). In addition, Hispanics, African Americans and Asians receive significantly worse antidepressant management care, such as follow up rates and antidepressant medication management (Virmig et al. 2004). In this regard, the literature suggests that Latinos and African Americans tend to prefer counseling services rather than medication (Brody 1997; Brody and Hunt 2006; Cooper et al., 2003; Dwight-Johnson et al. 2000). This reported preference for counseling may be at least in part a reflection of the lower availability of mental health professionals who can be ethnically matched with them, since Latinos and African Americans are underrepresented in those professions (Miranda and Cooper 2004).

Olfson and colleagues (2002) examined the national trends in outpatient treatment of depression between 1987 and 1997. They found that during this decade there was an increase in the proportion of people who received outpatient depression treatment. This trend was characterized by greater involvement of primary care physicians, greater use of psychotropic medications and increased availability of third party payment, but less psychotherapy and fewer outpatient visits. These changes coincided with the advent of better-tolerated antidepressants, the expansion of managed care, and the development of quick and efficient diagnostic tools for depression in clinical practice. As a result,
Aging Puerto Ricans’ Experiences of Depression Treatment

Antidepressant medications became mainstay, physicians assumed a more prominent role and psychotherapy sessions were less common and fewer for those in treatment (Olfson et al., 2002).

In sum, Hispanics in general and aging Puerto Ricans in particular are believed to be vulnerable to under-treatment while simultaneously they are at high risk of experiencing depression. Given the history of out-patient mental health policy and its implications for both minority and immigrant populations, this disadvantageous situation rings especially true with respect to access to quality depression treatment. For this reason, in the present study, we hypothesized that aging Puerto Ricans in Massachusetts would have encountered barriers to obtaining adequate depression treatment and we set out to explore their perceptions and experiences through the use of in depth ethnographic interviews.

METHODS

This paper uses data collected for the Boston Puerto Rican Health Study (BPRH)—the main project of the NIH funded Center on Population Health and Health Disparities housed at Tufts and Northeastern Universities. The BPRH is an ongoing longitudinal cohort study (1,500 participants at wave 1) that examines how psychosocial stress and the development of allostatic load affects health outcomes for aging Puerto Ricans (Tucker, et al., 2010). Extensive data for Puerto Ricans ages 45-75, including dietary intake, genetics, components of allostatic load, anthropometric measures, and health and use and access of health care; it also includes a number of scales including the Perceived Stress
Aging Puerto Ricans’ Experiences of Depression Treatment

Scale (PSS), the Center for Epidemiological Studies (CES-D) depression scale, Life Events Inventory (LEI), the Norbeck Social Support Questionnaire (NSSQ) and an acculturation scale. The cohort data collection is currently in the middle of a third wave of interviews.

One of the sub projects conducted at Northeastern consisted of a qualitative data collection that used semi-structured ethnographic interviews with a randomly selected sub sample of subjects (n=50) from the main survey (second author P.I.). A primary goal of this sub project was to better understand stress and social support in the Puerto Rican adult population living in the Boston area. A total of 50 interviews were completed, transcribed and coded. The main themes of these ethnographic interviews included: general quality of life, social support and social networks, self rated health/mental health and self care, sources of stress and ways of coping, religion and spirituality, work and care-giving and aging and retirement. From this sub sample, the first author of this article conducted 16 interviews, in which issues of depression, coping and treatment, and problems obtaining depression treatment were also explored in depth. In addition, through the interviews we also collected the subject’s stories of the reasons for migrating to the US, major life events that have occurred since first arriving and circumstances that have an effect on their overall mental well being. The interviews were between 1 to 4 hours long, all conducted in Spanish by the first author and digitally recorded. The interviews were transcribed, then coded and analyzed using the qualitative software MAXQDA. Excerpts discussing the respondent’s experiences with depression were extracted and further analyzed. In addition, a set of variables from the cohort study,
Aging Puerto Ricans' Experiences of Depression Treatment

including age, education, depression score and acculturation score, were added to the MAXQDA data and matched to the qualitative interviews. The PSS (Perceived Stress Scale) was used to measure level of stress at time of interview. This scale asks individuals to evaluate the extent to which various situations were experienced as stressful and the subject's feelings and thoughts over the previous month on a scale of zero to four (0=never, 4=very often) in the 14-item scale—the version used in this study. The PSS scores are calculated by reversing the scores in the responses and then adding all the individual scores. It is important to note that the PSS is not a diagnostic tool, and therefore there are no cut-off points that can be used to assess stress clinically. Nonetheless, the mean scores in the population may be used as a possible parameter to evaluate abnormalities. Cohen and colleagues (1983) found that, using the 14-item scale, the mean PSS score for Hispanic populations was 14, with a standard deviation (SD) of 6.9. In comparison, non-Hispanic whites showed an average PSS of 12.8 and a standard deviation (SD) of 6.2. Thus, Hispanics, as well as African Americans and other minorities, tend to exhibit slightly higher levels of perceived stress in comparison to non-Hispanic whites (Cohen, Marxman, & Mermelstein, 1983).

The CES-D depression scale was used to measure depression symptoms. This instrument is commonly used in epidemiological studies and has been proven a more valid measure for depression in Hispanic and aging Hispanic populations (Mahard, 1988; Robinson, Gruman, Gaztambide, & Blank, 2002). The questions ask subjects to indicate whether or not they have felt various symptoms of depression, and how frequently, during the last two weeks. In this scale, a score of 16 through 40 should be interpreted as an indication
Aging Puerto Ricans' Experiences of Depression Treatment

of symptoms of clinical depression.

To measure the level of acculturation, a scale was created from a list of seven variables that ask respondents which language they normally utilize for a range of daily activities, such as watching TV, reading newspapers and books, chatting with neighbors, at work, listening to the radio, with their friends and in their families on a scale form 1 (Spanish only) through 5 (English only), with 3 being both languages equally. Thus the score range in this scale is 7 through 35, in other words, the smaller the number the less acculturated to English the person is, and the higher the number the more Anglo-oriented, or more "assimilated," the person is.

Finally, we selected eight exemplary cases for this paper in which accounts of depression treatment were more salient in order to present in-depth case studies of the respondents' narratives.

RESULTS

A distinctive health care characteristic of the state of Massachusetts is the near universal health insurance coverage offered to its residents, especially since 2006 when an individual mandate for purchasing health care was enacted. For this reason, lack of insurance is not generally a major barrier to accessing mental health services, as it may be in other states. In this sample, the majority of the Puerto Ricans were insured primarily by MASSHEALTH—the Massachusetts Medicaid program—and Medicare, which included coverage for mental health services. In addition to these, the state also offers a program called FREE CARE, which financially assists those who are uninsured or underinsured in helping to pay for the care needed. Thanks to this state’s progressive
Aging Puerto Ricans' Experiences of Depression Treatment

health policy, financial barriers to minimal or basic health services are not a major issue for the aging Puerto Rican population of Massachusetts, a situation that sets them apart from other Puerto Rican populations across the United States, and more generally has made Massachusetts a model for the Affordable Care Act of 2012—popularly known as "Obama Care."

The majority of respondents in the study had prior experience with depression and/or they were currently depressed (as measured by the CES-D scale). Moreover, most present a low socio-economic profile, are not currently working and live in public housing. They also display low acculturation and educational levels and report a series of difficult life events, including health problems. Although most subjects expressed satisfaction with the health services received, when questioned about the treatment they had sought and received for depression the main concern expressed was the use of antidepressants. Prior studies have shown that taking medication for depression is often seen as a difficult step to take for many who suffer from depression, not only because of the possible side effects of the medication, but also because taking antidepressants signifies entering a stigmatized identity, that of being a mental health patient. Moreover, finding the right medication for each individual patient often presents challenges (Karp 1996). In this regard, Hispanics are even less likely to find antidepressants acceptable than Whites while they are simultaneously also less likely to have access to psychotherapy. However, the reasons why they are reluctant to follow an antidepressant regimen are still not well understood. Aging Puerto Ricans in this sample gave several reasons for their refusal to take antidepressants.
Aging Puerto Ricans’ Experiences of Depression Treatment

Accounts of treatment of depression through drugs

Taking antidepressants as being “on drugs”

Several subjects reported that they felt “drugged up" after taking antidepressants and/ or they feared other secondary effects of the drugs. In addition, subjects lamented that treatment for depression as well as other conditions is primarily focused on pharmaceutical drugs that do not tackle the root causes of their depression. This perceived growing reliance on anti-depressants could be explained by the policy changes introduced by managed care organizations and the preponderance of treatment offered at primary care settings in the form of an anti-depressant pill, a treatment that may be seen as more cost effective. The perceived predominance of pharmacological treatment for depression may also be result of the relatively low availability of Spanish-speaking mental health professionals in relation to the high number of Spanish speaking potential clients. Overall, given their limited options, these respondents rejected pharmacological treatment.

Exemplary Case 1

Mariana is 67 years old and lives in public housing with her divorced son. She has suffered asthma since childhood and reports that because of her condition her parents decided to take her out of school. With only two years of education, she can neither read nor write well in Spanish nor in English, and she confesses that she feels embarrassed to attend seminars or classes regarding health because of her illiteracy. Mariana has been living in Boston for over 30 years but experiences low acculturation to the Anglo culture
Aging Puerto Ricans’ Experiences of Depression Treatment

(acculturation score=14). A skilled seamstress, she worked first in the textile industry and then ran her own store in the same neighborhood where she resides. She then left the business to work as a foster mother and even adopted and raised two girls. However, because she did not contribute much to social security, now in her retirement Mariana faces problems making ends meet. For example, she recently had to give up her car because it was too expensive to keep. Her financial situation coupled with the difficult divorce case of her son and the fear that he would be put in jail are current sources of stress for Mariana (PSS=14). She also reports that she went through a depression episode after the death of her father; among other things she felt remorseful because her father told her that she had brought him to the United States to die. Although at the time of the survey Mariana did not present symptoms of depression (CESD=5), she recalls her experiences with taking antidepressants during her last depression episode:

“...Unless something big happens in the family and stuff... I try to keep my nerves under control [que eso de los nervios no me ataque mucho], because when my father died, I got sick [depressed] and I had to be in treatment for over a year, and they had me with... What was it? Valium? I don't know... I was almost completely drugged up, I could not even...I would walk and it seemed as if I was not touching the ground, and since then I said to myself that I would not go back to treatment, for I knew they would give me drugs for my nerves, and I do not like them. And then they gave me medicine to sleep and I do not like to take them either [...] I do not want so much medicine”
(Mariana, age 67).

Mariana explains that her treatment consisted exclusively of anti-depressive medications, which produced secondary effects. Because of this, she fears that taking drugs for depression, in addition to the other medicines she takes, may actually worsen her health.
Moreover, she complains that, in her experience, talk therapy is not normally offered.

Exemplary Case 2

Jimena is 61 and, like Mariana, she lives in public housing. Jimena has a bachelor’s degree in education from a well-known university in the East Coast and was for years a primary school teacher. She is bilingual and highly acculturated to the Anglo culture (Acculturation score=20). She is also a skilled artist who used to sell her paintings at several New England stores. After living for a while in a suburb in a nearby city, she reports that her children insisted that they wanted to be close to their cousins and grandparents in Puerto Rico and to live next to a palm tree. So she returned to Puerto Rico with her husband (Anglo American) to raise her children and later built a house next to her parents. There she enjoyed gardening with her mother, playing cards with her parents and relatives and taking vacation trips with them. Jimena reports that she lived a comfortable middle class life both in the U.S. and in Puerto Rico. However, after the death of her parents, especially her father, she started experiencing depression episodes and panic attacks. In addition, Jimena was diagnosed with kidney disease and Krohn’s disease; as a consequence, the doctors in Puerto Rico recommended that she return to the U.S. to obtain better treatment for her kidney condition. According to Jimena, her husband divorced her because of her illnesses; however, he continues to be supportive of her. Additionally, she also reports that both of her children have problems in their marriages and also suffer from depression. Because of her daughter’s marital problems and episodes of domestic abuse she often takes care of her infant grandchild, who was in the house during the interview. Besides her own health and financial problems, her
Aging Puerto Ricans’ Experiences of Depression Treatment

children’s marital problems cause her a great deal of stress. At the time of the survey, Jimena exhibited extremely high symptoms of depression (CES-D=48) as well as stress (PSS=41). Unlike Mariana, Jimena uses antidepressants to calm her nerves, but she is very aware of the physical secondary effects as well as the socio-cultural stigma associated with depression drugs:

Interviewer: And how do you cope with the depression?

Jimena: I take the medicines, I try to calm down, I try to keep my mind involved in other things; that is why I want to work.

Interviewer: Yes, aha, and with the medicine, how has your experience with the medicines been like?

Jimena: It has been bad. You do not feel well.

Interviewer: Why has it been bad...the secondary effects or...?

Jimena: Secondary effects... because in our culture it is not accepted...do you understand? They tell you that you are taking ‘dope,’ that this and the other, that it makes you sicker, that you should take teas... But they do not know what is happening within you.” (Jimena, age 61).

Although Jimena relays the discomfort caused by the medication’s secondary effects, she states that the major deterrent to using antidepressants is in fact the social and cultural stigma expressed by her network of co-ethnics; for example, the belief that medication will be detrimental to one’s health, that anti-depressants are “dope,” and that self care using natural folk remedies—such as various teas known to have calming effects—are preferable to medication for “nervios” [nerves]. This finding is consistent with prior studies which showed that the stigma of mental illness may prevent many Hispanics from seeking pharmacological treatment (Cooper et al., 2003; Hansen & Cabassa 2012).
Aging Puerto Ricans' Experiences of Depression Treatment

Despite the severity of her depression, Jimena feels conflicted about using anti-depressants, possibly because she herself has internalized some of these popular beliefs, but especially because of the fear of criticism by others.

Exemplary Case 3

Luis, age 51, lives with his wife and the youngest of their five children in public housing. He came to the U.S. at age 19 from a rural central part of La isla, as many refer to Puerto Rico’s countryside. He still remembers being in awe when he first saw a noisy elevated train that used to run across the city. But that was just one of many things that he had to grow accustomed to; he would also have to work during Semana Santa (Holy Week) something that as a devout Catholic he found strange. Luis had heard that in the United States there would be plenty of opportunities to get good jobs and get ahead. However, he soon discovered that due to language barriers and discrimination (acculturation score=11; 9th grade education), he would have to take the lowest skilled jobs that most Anglos did not want. For example, he once applied for a promotion in a maintenance job he had worked at for years, but the job was assigned to a White American who had been at the company for only one year, even though Luis’ job performance was highly rated. After that, hurt by what he thought was an unfair decision, Luis never spoke up or applied for any other promotion but resigned himself to just accept how the “system” worked to keep workers in the lower strata, especially poor Hispanics like himself. Subsequently, Luis suffered a fall at the hospital where he was working and injured his back. As a result, he is unable to work and he suffers permanent disability and recurrent depression, for which he was on treatment for over two years. Luis reports that he is very involved
Aging Puerto Ricans’ Experiences of Depression Treatment

in his Church and volunteers for everything, including doing visits to older Latinos who are sick and homebound. Besides that, and riding his bicycle, he reports lack of activities and boredom. Luis also reports that his priest, who was a good friend and confidant, died recently of a sudden death. At the time of the survey Luis exhibited high symptoms of depression (CESD=30) and stress (PSS=37).

*Interviewer:* And, how did the treatment work for you?

*Luis:* More or less, not one hundred per cent effective, no. I… I have… I have myself dealt with it [depression] on my own, yes. Because, look, the problem is that here [US] they [doctors] want to solve everything with pills. I do not like this. You go [to the doctor] and they give you a lot of pills, they want to solve everything with little pills and little pills… and sometimes problems… I do not know, no, I do not think problems can be solved that way. I am aware that yes, you have to prescribe pills, but they fill you up with so many pills that when you realize it you get worse, sicker, because [the pills] are damaging the other organs in your body. Because, even though the doctors tell you that no, that there are no secondary effects, but [sic] there are always secondary effects, always, yeah. These are chemicals that go into your body.

*Interviewer:* Yes, everything has some effect. But then, did you take the pills or…?

*Luis:* I got to the point I took pills, I got to take pills but no… I got to take pills, but I tell you, the way they made me feel those pills… I did not want to be that way. I did not want feel like that, like gone, like I was gone. I do not know, I do not want to be that way, I wanted to be normal, yeah.” (Luis, age 51)

Like Jimena, Luis struggled with the decision to take anti-depressants but, unlike her, he personally believes that this medication can negatively impact one’s health and quality of life, and that its effects are similar to those of other (illegal) drugs whose usage he disapproves. One may argue that the equivalency drawn by respondents between anti-
Aging Puerto Ricans’ Experiences of Depression Treatment

depressants and illegal recreational drugs is based upon their perceived effects. Thus, many fear that they will become addicted, that “drugs” will have deleterious effects, and that they could be the object of criticism by others for taking “dope.”

Avoiding antidepressants for fear of overmedication

Some scholars have critiqued the overmedication of the older adult population in the United States (Fick 2003). In this sample there is a high prevalence of chronic health problems, for which the respondents take multiple prescription drugs. Because of this, many of the interviewees report that they avoid taking antidepressants, since they consider that depression is a minor illness in comparison to the seriousness of the other illnesses afflicting them, and because they are afraid of the possible pernicious effects of taking a lot of medications or of the interactions among them. Mariana expresses this idea in the following quote:

“...Because... imagine! With so many pills that I take! And here all... I take sometimes twelve pills in the morning, and then in the afternoon sometimes I have to repeat, for example, the one for the pressure, for the calcium now, and all they [the doctors] tell you is: ‘PILLS, PILLS, PILLS’ and that is what is hurting my kidney. Umm, and sometimes I keep to myself the simple things like this [depression] so they [doctors] don’t give me so many pills.” (Mariana, age 67)

Mariana reports that besides having asthma, anemia and osteoporosis, she suffers from kidney disease and attributes it to medications taken in the past. For this reason, she is especially fearful of taking too many medications and hides certain ailments from her doctors in order to avoid being prescribed yet another pill.
Aging Puerto Ricans’ Experiences of Depression Treatment

Underrepresented groups have been found to be less likely to adhere to a prescription drug regimen, but it is still not clear why this is so (Miranda and Cooper 2004; Vinig et al. 2004). With regard to aging Puerto Ricans and other language minority groups, it is worth pointing out that even though interpreter and translation services have improved at sites that deliver health care services, there is still need for improvement in other aspects health care services. For example, Balkrishnan (2007) has noted that pharmacies very rarely have translation services available nor do they generally translate the labels placed on prescription drugs. Because of this, limited English speakers might not obtain adequate information or be educated on how to use and adhere to pharmacological treatment (Balkrishnan 2007).

Taking antidepressants as a last resort in extreme cases of depression

Several interviewees indicated that they would be willing to take antidepressants as a last resort in extreme situations, and only if other measures did not work for them, since they consider these drugs addictive and dangerous. Thus, they stress the fact that their depression arises from difficult and concrete life circumstances and that once their problems are addressed they would feel better. It is generally believed that drugs in most cases are unnecessary and would only cause their condition to worsen. In several cases, subjects report seeking treatment that includes both psychotherapy and drugs, although they only accept, eagerly, the former and refuse to take the antidepressants.

Exemplary Case 4
Carmen, age 66, came to the U.S. mainland from Yabucoa, a rural part of Puerto Rico, over forty years ago. She wanted to leave behind her routine because making a living in Puerto Rico was very hard and jobs there were physically demanding. Carmen had heard from two siblings who lived in Boston that jobs in the U.S. were better. So she moved to Boston and later met her husband. They subsequently moved to New York and to L.A. with their only child. Carmen reports that her husband worked as a dark room technician developing photographs for large industries and that he, over time, developed work related illnesses, such as migraines and over-sensitivity to sunlight. Moreover, at times he became violent and desagradecido de la vida [ungrateful at life]. Carmen thinks that perhaps because he did not want to make her and their child suffer, one unexpected day her husband told her that he wanted a divorce. After the dissolution of her marriage she, and her child, moved back to Boston to be close to relatives who were living in the area. She went back to work in the same factory where she had previously worked—in fact she remained there until recently. During a trip to Puerto Rico, in which she went to spent time with her ailing father, she fell on the ground and broke her left arm. As a consequence, she became disabled and to this day, Carmen cannot close her injured hand. She, currently, receives a social security check and lives in a studio apartment in public housing for seniors and people with disabilities. Three years back, the mother of her grandchild (her son’s ex wife) asked her to assume custody of her autistic grandchild, because she did not feel she could continue doing it herself (she died soon after). Taking full responsibility for this child with special needs has been both a blessing and very stressful, according to Carmen, but she has received the support of several friends in the building where she lives and of her social worker; as well as the economic support of her
Aging Puerto Ricans’ Experiences of Depression Treatment

son who lives in Chicago with his new family but provides child support. As someone who does not speak English (acculturation=14; 4th grade education or less) she often depends on a “friend” to serve as interpreter, whom she has to pay. Another stressor for Carmen is her housing situation. She and her grandchild live in a studio apartment that is too small for them. The doctors tell Carmen that especially because of her grandchild’s autistic condition, they need a larger space. Indeed, Carmen has been sleeping on a sofa for two years while her grandchild sleeps in the only bed. She has a long-standing request to the housing authority for a larger apartment but her efforts have been unsuccessful. Because of this, Carmen says that for the first time in her life she has felt discriminated against by the housing authority. This stressful situation (PSS=34) is reported to have triggered a depression for which Carmen is currently under treatment (CESD=30).

Interviewer: And how are you dealing with the depression?

Carmen: Well, I am going to the psychologist, and... and I did not want to take pills, because... I have heard a lot of people saying that after you start taking pills, and taking pills, that like they get used to the pills... and if they do not have the pills that... and I am not... I go to her [the psychologists] and I talk... and I try to... The other day she saw me, she looked for me, because those days I was feeling really bad, and then she said to me “Ay, I think you are going to have to...” and I said “Ay, no, I still do not want pills, I do not want pills.”

While Carmen wants to move to a larger apartment, she does not want to move out of her current building because there she has developed network of supportive relationships and friendships with a group of Spanish speaking elders and she feels that those supportive networks would not so easily be found elsewhere.
Carmen: ...I say: "I do not want to move out of this building, I do not want to move out of here and things... I say: I am going to stay in this roto [dump] until... [laughter]. But then when I went back to her [the psychologists] and I had already received the letter [a letter from the department of housing] and then, they had already approved the transfer for the handicap, so I was feeling more calmed down, and I told her NO, NO, because she was going to... she was putting me on a waiting list to see the doctor to prescribe pills for me for the depression. So with respect to that I have not..."

In the quote above, Carmen suggests that there is an inverse relationship between obtaining a larger apartment and receiving a prescription for depression. In other words, her success in being listed as needing a move because of an existing handicapping condition meant that she would move up on the waiting list at the department of housing. This small victory made Carmen hopeful that what she perceived as the trigger of her depression might be resolved in the near future. Moreover, this new development also allows Carmen to reason with her social worker that she will not need to place her on a waiting list to see a Spanish speaking psychiatrist, and will not need to be prescribed the anti-depressants that she so fears.

_Taking antidepressants but having inadequate psychological treatment_

Some of the subjects accepted adhering to a drug regimen for depression but feel that they are not getting adequate psychological treatment.

_Case 5_

María is 62 years old and lives in public housing with her husband in a town adjacent to
Aging Puerto Ricans’ Experiences of Depression Treatment

Boston. She came to the United States from Coamo over 30 years ago and was always a stay at home mother. María reported that she and her family were lucky that her husband always worked while she stayed home to care of him and the children, and that they were never on welfare. Occasionally, she worked from home as a babysitter. She seems proud when she says that one of her children is a policeman in Florida and another is a teacher in Massachusetts. María currently baby-sits for some of the grandchildren, although communication with them is not easy at times because they do not speak Spanish and her English is very limited (accluturation=12; 4th grade education or less). With the last child moving out of the home and a personal diagnosis of facial cancer, as well as other health problems, she reports that these health and family situations triggered a depression that has been ongoing for approximately the past five years. María reports that she often feels lonely and is not involved in out of home social activities besides her therapy group. She does have a friend from the group and maintains telephone contact with her. María became emotional when she confessed that she was very worried about her facial cancer. However, she has not received individual therapy for her depression, only antidepressants and group therapy. At the time of the survey, María exhibited very high symptoms of depression (CESD=38) and stress (PSS=31).

Interviewer: And you told me that you suffer from depression. Are you taking something for the depression?

Maria: Yes, I have… I have pills for everything

Interviewer: Pills, aha.

Maria: For sleeping also, for the cholesterol…

Interviewer: So, you have a collection of pills…!

Maria: Yes, I have a pharmacy over there (laughter)
Aging Puerto Ricans’ Experiences of Depression Treatment

Interviewer: (laughter) and do you take all your pills?

Maria: Yes, I put them all in a little box there and that is why it is not difficult at all [to take the pills]

Interviewer: And when did you start with the depression?

Maria: Ay! I think that a long time ago, a long time ago, like five years ago.

Interviewer: Around five years, and what kinds of treatment have you received?

Maria: Well, sometimes I do not feel well; sometimes I do not feel... I say to myself that I do not want... I do not want to get out of the bedroom, I do not want to comb my hair, I do not want to do anything, nada, nada, nada. Sometimes I feel a little better, I am in better spirits, and when I am in better spirits I do everything around the house very quick [inaudible]

Interviewer: and have you gone to psychotherapy or to a psychologist?

Maria: No, the only thing I have is the medicine for the depression and for sleeping, and there is also a group that a few of us attend, that is a therapy group. But I would like to have for me only [individual therapy].

Interviewer: Oh, ok, you do not have individual therapy

(...)

Maria: And how does the group work for you?

Interviewer: Well, I like it.

Maria: And how is it that they did not give you individual [therapy], do you know?

Interviewer: Because sometimes they have, how do you say it? That like you have to wait...

Maria: Like waiting lists or something?

Interviewer: That you have to wait a long time, yes.” (María, age 61)

In spite of showing very high symptoms of depression and having a diagnosis of cancer, María does not receive individual mental health therapy; instead, her treatment consists of anti-depressants and attending group therapy. Like other respondents who are not fluent in English, the inadequate access to individual talk therapy seems to be connected.
Aging Puerto Ricans’ Experiences of Depression Treatment

to language barriers and a shortage of Spanish speaking therapists relative to the number of potential clients in the area.

Antidepressants work

A few interviewees reported that they have struggled with mental illness throughout their lives. The depression is described as being more chronic and complicated with other mental health diagnoses. These respondents also indicated never having seek help for their mental problems while living in Puerto Rico, and that they had waited too long to look for help once their condition had reached an advanced stage. In those cases, the subjects felt that drugs were beneficial to them—that they could not manage their condition without them.

Case 7

Carmina, age 61, came to the United States with her parents and her ten younger siblings when she was still an adolescent. She remembers that it was close to Christmas time and it was very cold and snowy. Carmina was sent to Catholic school, but she had a hard time adjusting as she could not understand a word the teachers were saying, and often got into trouble because she did not know how to recite the mandatory prayers in English (acculturation=15, 6th grade education). Carmina was not happy to be in Boston, she wanted to go back to Puerto Rico where the weather was warm and she enjoyed going to school, but she knew her parents would not let her go back, and she always did as she was told and kept her feelings to herself. After her unsuccessful school experience, she stayed home to help her mother raise her ten siblings. Carmina reports that since
Aging Puerto Ricans’ Experiences of Depression Treatment

childhood she suffered from nervios [nerves] but did not go to a psychiatrist until later when her condition was very advanced. In the United States, Carmina developed phobias that afflict her to this day; because of this she cannot venture outside her immediate neighborhood block and is afraid to be outside after dark. In 1968, Carmina had a terrible car accident in which she was thrown out of a car from a back seat window. As a result, she was in comma for six months and had two operations in her head. She also hurt a leg and an arm and to this day she experiences loss of memory and pain from her old injuries. Carmina was married and had two children and reports that she started experiencing depression after she married and that her ex husband gave her malos ratos [hard times]. She did not like being married and she wishes she had become a nun, an hermanita de la caridad, like her cousin. But because she did not have a school diploma she was told that she could not do so. She also wishes she could have continued her education so to have better jobs, instead of doing laundry, babysitting and working in factories. She now lives in public housing on a very low income and cannot afford to buy many necessities such as clothes. She reports that she has received psychiatric treatment for years and she has stayed, twice, for short periods of time in a psychiatric hospital. In the past two years, Carmina has experienced several losses in her immediate family, the deaths of her mother and a sister that lived in the same building, as well as one other sister. As a consequence she went through a deep depression and reports that she tried to commit suicide through starvation, but all she managed to accomplish was losing a lot of weight. During the interview, Carmina reported that she still feels depressed and has suicidal ideas (CESD=28, PSS=36).

Interviewer: …but with the psychiatrists that you have gone to and the doctors, do you feel they
Aging Puerto Ricans’ Experiences of Depression Treatment

have helped you? How has your relationship with your psychiatrists been like?

*Carmina:* Yes, they have helped me. Talking to them, making me understand… Because, sometimes one does not understand… They have helped me understand how is this, how is that… how is life, that combined with the medication.

*Interviewer:* So the medication helps you?

*Carmina:* Yes. If it was not for that… MUCHACHA! [girl!] [without the medication] I would have been… I do not say I would be buried, but I would have been in a madhouse.

According to Carmina, the medications in combination with the talk therapy she received at the psychiatrist’s office have helped her enormously. It is worth noting that Carmina did not report experiencing problems obtaining treatment. This could be explained by the severity of her mental health problems and the fact that she has a long history of mental illness. Indeed, she wished she had sought help earlier since, as mentioned, as she has been struggling with nervios since she was a child and still living in Puerto Rico.

*C*ase 8

When Aurora, age 69, was a young woman she lived in Puerto Rico with her four small children from two different marriages. She reports that the fathers of her children were sinverguenzas [a waste of time] and never helped her, so she had to fend for her family by herself. Aurora worked cleaning houses, in dining services, and later she was given a parcel of land and a house through a government program; in exchange, she had to work the land to make a living. Unfortunately, Aurora developed heart disease and problems with her nervios [nerves] – though she never went to a psychiatrist in Puerto Rico.

Because of her health problems, she was unable to continue the strenuous kind of work she had been doing anymore. So one day, about forty years ago, Aurora decided to
migrate to the US *pa echar palante* [to move ahead]. She worked in a factory assembling light bulbs (6th grade education or less, acculturation score=10), but she continued having *nervios*, and one day in 1978 she felt very sick and was diagnosed with ventricular cardiac arrhythmia. After that, she stopped working and started collecting social security. Later, she gave her house to a son and was able to qualify for disability; thus now she makes a little more than six hundred dollars a month and pays two hundred and eight dollars for the studio apartment in a public housing for seniors and disabled people where she has been living for the past six years. Aurora has experienced several losses in the recent past. One of her sons was found dead of a drug overdose in New York. Her mother, whom she had brought to the U.S., died of cancer, and a sister also died of a heart attack. One brother was killed while being robbed for his social security money, and another brother killed his own toddler son. Even though she is herself very sick, Aurora still checks on a sister who has for years been interned in a mental institution nearby. Luckily, Aurora has the support of her ex-partner who comes by everyday to see her, and her living children with whom she says she has good relations. Aurora reports that she feels stressed out because, given her mobility problems, she needs a larger apartment with a bedroom. She suffers from several chronic health conditions including heart disease, digestive problems, an anxiety disorder and depression (CES-D=16, PSS=19).

*Aurora:* ...they gave me Zoloft 50 mg

*Interviewer:* Oh, Zoloft

*Aurora:* First they gave me half...

*Interviewer:* Yes, to see how you tolerate it...
Aging Puerto Ricans' Experiences of Depression Treatment

*Aurora:* They say they gave me one of twenty-five, they gave me one of fifty and they have gone... they have changed...like four times...and they have not changed the pills thank the Lord!

*Interviewer:* So you take Zoloft 50 mg

*Aurora:* Aha, and I say, lucky me!

*Interviewer:* It makes you feel better?

*Aurora:* The Zoloft that... that makes me feel more calmed down. You know, because here [apartment building for seniors] you are not your own boss, because you know that this belongs to the government, but here I say I have my *chavos* [money] and they cannot kick me out of here, they cannot scream at me, or anything like that. You know that....

(Aurora, age 69)

Aurora is content with the pharmacological treatment she receives. The current dosage is effective and was gradually increased to a working level; in fact she did not experience any ill effects with the medication. However, it is also interesting to note that Aurora associates the rising of symptoms of anxiety/depression to her living conditions. Because she rents a studio in public housing for seniors and people with disabilities, she is afraid of being asked to leave if her nerves cause her to overreact (e.g. screaming) to potentially stressful situations. Thus, the medication helps her control her emotions while living in a stressful residential environment where she feels relatively powerless.

**DISCUSSION**

For decades, epidemiological studies have shown disproportionally high rates of depression and psychological distress among Puerto Ricans. Yet, very little is known about their experiences with treatment for depression and other mental disorders. Indeed, the process by which people come to realize of mental illness and how they seek mental health care are important research items that have not been sufficiently investigated,
Aging Puerto Ricans' Experiences of Depression Treatment

particularly among underserved minority groups (Bazargan et al., 2005b). Given the history of outpatient mental health services in the United States, especially as it relates to urban minority and immigrant populations we hypothesized that Puerto Rican elders in Boston would face problems obtaining quality depression treatment. Through the in-depth ethnographic interviews, we found that older Puerto Ricans feel that treatment for depression in the US context is too focused on pharmacological treatment that is not always adequate for their particular case.

In general, subjects identify problems that have been found to be correlates of depression in quantitative research. They believe that their depression is triggered or affected by social stressors that are not properly addressed, such as housing problems, financial problems, lack of jobs and activities and social isolation. Indeed, many subjects report that their depression is caused by difficult social circumstances and life events that are related to poverty, gender status and ethnic minority status. The subjects also indicated that health problems and disability are major sources of stress; moreover, the fact that they already take multiple prescription drugs for other health conditions also contributes to their resistance to accept pharmacological treatment for depression. They believe that while psychotherapy helps people cope with life's difficulties, antidepressant medication is useful only in extremely severe cases of depression. Furthermore, antidepressant drugs are believed to be a kind of “dope,” highly addictive, and with secondary effects that can damage other organs in the body and make their depression and general health even worse. The interaction between reported inadequate treatment options, cultural beliefs, low acculturation, language limitations and complicated health profiles may also
Aging Puerto Ricans’ Experiences of Depression Treatment

contribute to lack of trust in medications or lack of adherence to a prescribed regimen. For this reason, many avoid seeking help for their depression and, if they do, they resist taking antidepressants. As general guidelines indicate, depression treatment among the older population often requires addressing a range of needs that go beyond the strictly medical problems, such as living conditions and social isolation, that require the coordinated intervention of several agencies (NICE, 2004).

Previous studies have found that Hispanics prefer psychological treatment over medication (Cooper et al., 2003; Barzagan et al., 2005), but to our knowledge, no study to date had addressed the reasons for avoiding pharmacological treatment and treatment in general. Given the lower availability of Latino and Spanish speaking mental health professionals to provide direct treatment, and the current national trend of treating depression at the primary care site by physicians, it is not surprising to find that older Puerto Ricans feel that the treatment options available to them are far from optimal. This—coupled with limited English ability, low acculturation, financial difficulties and the belief that antidepressants are a kind of “dope”—may prevent many from adhering to treatment. One plausible interpretation for the persisting social norm of viewing use of antidepressants as carrying the same social connotations as if using illegal drugs (“dope”) in this group may be that they have internalized majority stereotypes about Puerto Ricans and the poor as prone to be drug users. Thus, this may be an attempt to disassociate themselves from that negative image by rejecting to use anti-depressants. This suggests that the use of anti-depressants in US society has become more normalized; but there remain cultural niches where perceptions of the use of depression medications are seen
Aging Puerto Ricans' Experiences of Depression Treatment

through a different lens.

An emphasis on screening for depression and expansion of treatment must be accompanied by a parallel emphasis on reaching underserved minority populations (Bazargan et al., 2005). These would include taking measures to increase the representation of Latino mental health providers, especially in psychological and counseling services, but also in pharmaceutical services so that—when needed—Latino clients can obtain adequate education on the use of prescription drugs for depression. In the final analysis, one of the main lessons gained from this ethnographic exploration is the need to avoid simplistic interpretations of the expressed rejection of pharmacological treatment as just a “cultural” response. Puerto Ricans have been historically, and continue to be, a population that is underserved in the mental health arena, while they are also afflicted by multiple social and health problems. It is imperative to understand their reasons for avoiding drug therapies in order to continue make a dent on the treatment disparities for depression and other mental health ailments facing them by increasing the representation of Latino and/or culturally competent providers in the field of mental health.

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Aging Puerto Ricans’ Experiences of Depression Treatment

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Aging Puerto Ricans' Experiences of Depression Treatment


