DEPRESSION AMONG HISPANICS: UNDERSTANDING DIFFERENCES IN SCREENING AND DIAGNOSING DEPRESSION

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DEPRESSION AMONG HISPANICS

DEPRESSION AMONG HISPANICS: UNDERSTANDING DIFFERENCES IN SCREENING AND DIAGNOSING DEPRESSION

Abstract

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Depression is a debilitating and disabling disease. In the United States, racial and ethnic minorities have higher rates of depression than non-minority groups. Hispanics are the fastest growing minority in the United States and will become the predominant ethnic group by 2020. Factors such as high poverty level, lack of health care insurance, inaccessibility to health care, low worker productivity, language barriers, and immigration related stressors, place Hispanics at greater risk for depression. The purpose of this literature review is to increase awareness among primary care providers on screening Hispanics for depression; in order to increase the possibility of adequate and prompt treatment. The review also examines some Hispanic ethnic-specific characteristics such as resilience, family and community integration, and their use as positive factors when battling psychological stressors and treating depression among Hispanics.

Keywords: Hispanics, depression, screening, primary care.
# DEPRESSION AMONG HISPANICS

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Depression among Hispanics: Understanding Differences in Screening and Diagnosing Depression

Introduction

The National Institute for Mental Health (NIMH) reported depression as one of the most common mental health disorders in the United States with a prevalence of up to 9.1% in the adult U.S. population (2008). Depression not only affects the individual, but also vicariously affects persons caring for the individual (NIMH, 2008). Researchers at the World Health Organization (WHO) reported that major depression is expected to be the second leading cause of morbidity worldwide by the year 2020 (Murray & Lopez, 1997). Currently, major depression is the leading cause of disability in the United States for adults between 15 and 44 years of age (Farr, Dietz, Williams, Gibbs, & Tregear, 2011). Depression left untreated can cause months of unnecessary emotional suffering, an increase in risky behavior, substance abuse, and suicide. Depression is the second most common chronic disorder seen in primary care (Sharp & Lipsky, 2002), and negatively affects the success of treating other chronic diseases when they co-occur (CDC, 2010a; Farr et al., 2011). If effectively treated, depressive signs and symptoms would decrease in 80% - 90% of patients (Valente & Nemec, 2006).

Hispanics are the fastest growing ethnic minority group in the United States (U.S. Census Bureau, 2007), and will become the predominant ethnic group by 2020 (Le, Lara, & Perry, 2008; U.S. Census Bureau, 2002). According to the definition used by the United States Census Bureau (2004), a Hispanic or Latino is any person of Mexican, Cuban, Puerto Rican, South or Central American, or Spanish culture or origin, regardless of race. The Center for Disease Control and Prevention (CDC, 2010a) reported significantly higher rates of psychological distress and depression among racial and ethnic minorities than among non-
Hispanic whites (CDC Morbidity and Mortality Weekly Report, 2010a). The prevalence of depression among Hispanics is 4%, and among non-Hispanic whites it is 3.1% (National Center for Health Statistics, 2010). However, non-Hispanic whites receive mental health treatment three times more often than Hispanics according to the U.S. Department of Human Services Office of Minority Health (2005).

Anecdotal evidence from a rural primary care clinic which serves a large Hispanic seasonal and migrant farm worker population, as well as low income, uninsured, and underserved clients, suggests that the majority of the clinic patients who were diagnosed with depression and were on anti-depressant treatment were non-Hispanic whites. In order to further evaluate this observation, an informal assessment of clinical data was completed through their electronic medical records. A two year snapshot (2009 & 2010) revealed the clinic had 655 adult patients with the diagnosis of depression (ICD 9 code: 311); 70% of these patients (n= 461) were white non-Hispanics, 27% (n= 178) were Hispanics, and 16 patients (3%) were determined as “other”. These observations corroborates the numbers revealed by the CDC, which were national statistics drawn from the communities.

**Purpose Statement**

The purpose of this literature review project is to increase awareness among primary care providers on screening Hispanics for depression in order to increase the possibility of adequate and prompt treatment. The review also examines some Hispanic ethnic-specific characteristics such as resilience, family and community integration and their use as positive factors when battling psychological stressors and treating depression among Hispanics.
Literature Search Strategies

A literature search was performed on the internet through an online University library database using advanced search engines EBSCOhost, CINAHL, MEDLINEplus, and psycARTICLES. The keywords *Hispanics, depression, screening,* and *primary care* were used to identify 47 relevant articles. These articles were divided into four conceptual categories: (a) overview of depression among Hispanics in the United States (U.S.), (b) screening rates, (c) impact of depression among Hispanics, and (d) Hispanic specific ethnic-cultural differences in perception of depression.

Theoretical Framework

Culture modifies humans and humans modify culture (Choi, 2002). Leininger's (1998) cultural care diversity and universality theory suggests that understanding and considering a person's culture is necessary to competently and adequately assess, diagnose, and treat (McEwen & Willis, 2011), facilitating a holistic approach to the phenomena that affects an individual. Leininger (1998) expanded the concept of culture and gave special attention to the different dimensions of culture to include spirituality (religious and philosophical), social, technological, political and legal, educational, economic, language, family, and beliefs (ethno history) learned through generations as part of the cultural and social structure dimensions (Kaakinen, Gedaly-Duff, Coehlo, & Harmon-Hanson, 2010). Moreover, the concept of micro-ethnographies refers to a narrowly defined cultural grouping that defines themselves due to shared and common characteristics, including gender. Therefore, Leininger's culture can be applied to the following groups: Hispanics, Hispanic females, Hispanic adolescents, and Hispanic males (Porrett, & Cox, 2008). All of these dimensions impact the individual’s concept of health, illness, death and cure.
Under Leininger's theory of cultural care diversity and universality, nursing care practices include: (a) professional care-cure systems that are learned in professional teaching and (b) generic or lay care-cure systems culturally learned and transmitted over generations (Gebru, Ahsberg & Willman, 2007). Increasing the awareness of transcultural nursing care among advanced practice nurses results in providing better care, because both care and nursing are cultural experiences (Wikberg & Eriksson, 2008).

**Literature Review**

**Overview of Current Depression Among Hispanics in the United States**

In the Surgeon General's report from 2001, minorities, including the Hispanic population, are considered vulnerable, underserved and in high need for mental health care (U.S. Department of Health and Human Services, 2001). Characteristics such as lower socioeconomic status, lower education level and occupation have been related to increased incidence in mental illnesses among Hispanics (Mann & Garcia, 2005; O'Connor et al., 2008). The Hispanic population is at greater risk for mental health disorders due to their high poverty level, low worker productivity and difficult family relations (Mann & Garcia, 2005; Merz, Malcarne, Roesch, Riley, & Sadler, 2011). Hispanics have the lowest per capita income among minority groups, which increases their risk for mental illness (U.S. Department of Health and Human Services, 2001). The percentage of Hispanics living below the federal poverty level (20.7%) is more than double that of non-Hispanic whites (9.0%). Moreover, 32.1% of Hispanics lack health insurance, compared to 10.4% of non-Hispanic whites (Zambrana & Carter-Pokras, 2010), impacting their health care access. Not surprisingly, given these factors, Hispanics' use of mental health care services is lower than use among non-minority populations (Chaudron et al., 2005).
Of particular concern are sub-populations within the Hispanic population, specifically women and children. Depression starts early in life among the Hispanic population. Maternal depression can negatively affect pregnancy outcomes with increased rates of low birth weight and preterm delivery (Farr et al., 2011). Children from mothers who suffer from depression are at higher risk of developing a childhood depression disorder and may have detrimental intellectual development, behavior, and mental health (Farr et al., 2011). In addition, depressed parents have a decreased capacity to communicate and solve conflict with their children (D’Angelo et al., 2009). Just over 36% of first generation immigrant Latino youth report experiencing sadness and hopelessness, 15.9% have considered suicide and 10.2% have attempted suicide (Potochnick, & Perreira, 2010). Hispanic females suffer more depression than non-Hispanic females, but get diagnosed less often (Chaudron et al., 2005). In 2009, 20.2% of Hispanic females between 9th and 12th grade had seriously considered suicide, compared to 16.1% among their white, non-Hispanic female counterparts (CDC, 2010a). Because Hispanics face particular risk factors for depression and this research suggests they are under diagnosed, it is important to understand more clearly the assessment and screening practices currently in use.

**Screening Rates**

The U.S. Preventive Services Task Force (USPSTF) recommends that providers screen adult patients only when support from clinical that can provide depression care (clinical staff that can provide some coordination or direct care for depression) to diagnose, treat and follow up accurately (U.S. Department of Health and Human Services: USPSTF, 2010). Diagnosing depression is a challenge for clinicians that are not psychiatric specialists. Currently, only 36% of depressed patients that present to primary care are diagnosed accurately (Farr et al., 2011). For example, the overall reported depression screening rates among women vary from 33% to 84%
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depending on the institution. Some studies conducted in rural health clinics showed screening rates as low as 2.4% for documented formal screening (with screening tool) to 33.2% of informal (without mention of screening tool) documented screening (Farr et al., 2011). Trials have shown that increasing depression screening especially among high-risk populations increases the recognition of depression by the providers and the likelihood of treatment/intervention for patients (Farr et al., 2011). Recognition of depression nearly tripled when screening for it took place (Farr et al., 2011).

Impact of Depression Among Hispanics

In general, depression is a disorder that can cause a significant decrease in function if left untreated (Nadeem, Lange, & Miranda, 2009). An environment that is culturally insensitive only delays the diagnosis of depression and the appropriate treatment. This delay in treatment decreases functionality, increases disability, adds to loss of work days, and imposes limitations in performance of daily activities (U.S. Department of Health and Human Services, 2001). According to the 2008 National Healthcare Quality & Disparities Reports, among adults diagnosed with a major depressive disorder, 73.3% of white patients received treatment, but only 51.8% of Hispanic patients received treatment (Agency for Healthcare Research and Quality, 2008).

One of the gravest consequences of depression is suicide, and it is not an exception among Hispanics. A study on depression and suicidal ideation among school-aged Hispanic children in the Chicago area revealed that up to 19.7% of kids were depressed and 38% had suicidal ideation (Muennich-Cowell, Gross, McNaughton, Ailey, & Fogg, 2005). The Office of Minority Health (OMH) reports that in 2007 suicidal ideation among Hispanic females grades 9-12 was 21.1% compared to 17.8% among non-Hispanic whites (U.S. Department of Health and
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Human Services, 2008). In that same year, 14% of that population actually attempted suicide compared to 7.7% of non-Hispanic whites. In 2007, 6.3% of the Hispanic male students in grades 9-12 attempted suicide, which is more than double the percentage among the non-Hispanic white male students (3.4%) (U.S. Department of Health and Human Services, 2008). The actual death rates, however, for boys ages 15-19 years was greater in the non-Hispanic white population (13.3%) than Hispanics (7.9%). Among girls between 15-19 years old, the suicide death rate was equal among non-Hispanic white and Hispanic females at 3.0% (OMH, 2009).

Family and community are primary pillars of support in the Hispanic culture. Family connectedness, parent-child communication, and parental caring are protective factors for Hispanic youth. Suicide attempts are 11 times greater in Hispanic youth that report low levels of family connectedness and 10 times higher in those youngsters that are unable to communicate with their parents and that perceive a low level of parental caring (Garcia et al., 2008).

High risk behaviors are more prominent among depressed Hispanic teenagers. Hispanic girls are more likely to drink alcohol, use illicit drugs, have higher pregnancy and birth rates before the age of 20, and higher high school dropout rates than their White and African-American counterparts (Maradiegue, 2010; Melnyk et al., 2009). These risky behaviors are associated with depression which, as mentioned, is high among Hispanic teenage girls (Maradiegue, 2010).

Depression has also been linked to high risk sexual behavior, greater number of sex partners, increased risk for sexually transmitted diseases including HIV, and unintended pregnancies among low income Hispanic women (Garbers et al., 2010). Maternal depression has been linked to compromised child safety and has long term adverse effects in the social, emotional, and cognitive states of children (Chaudron et al., 2005). All of these factors can
contribute to an increase in child morbidity and even mortality. Treatment of maternal depression will improve outcomes in the child (Nadeem, Lange, & Miranda, 2009).

Among Hispanics, health insurance has been found to be the most important factor that determines access to mental health care, more important than language, ethnicity and even income. Health care access and quality are worsening for Hispanics in the U.S. (Zambrana, & Carter-Pokras, 2010).

Disparities in access to mental health care are particularly noticeable among the youth, 47% of youth minorities (African American and Hispanics) had unmet needs for mental health care compared to only 30% among non-Hispanic white youth. Based on the guidelines from the American Psychiatric Association for minimum adequate mental health care, only 28% of the minority population received adequate care compared to 36% of the white population who received minimum adequate mental health care (Alexandre et al., 2010). This same study also demonstrated an increase in the odds of receiving adequate mental health care when the population had Medicaid/SCHIP, regardless of race or ethnicity.

Hispanic-Specific Ethno Cultural Differences in Perception of Depression

Depression is experienced, expressed, and communicated differently in every culture (Merz et al., 2011). Hispanics are less likely to be aware of mental health symptoms and less likely to seek mental health care for them. In a study conducted by Alexandre, Younis, Martins, and Richard (2010), the authors suggest that mental disorders are interpreted and manifested differently according to race and ethnic group, since cultural and ethnic factors are sometimes an obstacle to appropriate care for minorities. Some mental health disorders are missed or underdiagnosed among minorities and this can be reduced by being alert and aware of ethno cultural specificities (Choi, 2002). Research shows that at least half of the Hispanics in need of
professional mental health care seek care from a general medical provider (Heilemann, & Copeland, 2005). When treatment choices are given, Hispanics, especially women, prefer to receive counseling rather than pharmacologic treatment (Pieters & Hielemann, 2010). There is a higher acceptance for psychotherapy over pharmacotherapy among Hispanics and African Americans (Gonzalez et al., 2010). Moreover, minorities, including Hispanics, use more alternative care outside the health care system instead of conventional care (such as clergy, pastoral and family counseling) partly because there is a generalized mistrust among minorities on the traditional care system (Alexandre et al., 2010) and/or perceived discrimination (Gonzalez et al., 2010). Seeking help for emotional problems is more highly stigmatized among minorities than among whites, which makes it less likely for minorities to seek mental health treatments (Nadeem et al., 2009).

Among Hispanics that do not speak English, the language barrier increases levels of stress and depression (Ding & Hargraves, 2009). A study conducted by Heilemann and Copeland (2005) found that low acculturation, measured as a preference for speaking Spanish, was a significant cultural barrier to seeking mental health care among Hispanic females. Minorities that are non-English speaking can feel more socially inhibited from discussing openly the functional limitations they might be experiencing from depression (McGuire et al., 2008).

The 2001 Surgeon General report points out that among undocumented Hispanics fear of deportation for themselves or their families creates a generalized mistrust toward government-operated organizations. This is a contributing factor for some Hispanics who report not seeking mental health treatment despite significant depressive symptoms.

Lifestyle changes made by Hispanic immigrants in the U.S. during their acculturation process can increase negative health care outcomes including mental health (O’Connor et al.,
Research indicates that more acculturated Hispanics deal with higher levels of psychological distress, in part due to alienation and discrimination (Heilemann et al., 2004). Immigrant Hispanics leave their country of origin to make a better life for themselves and their family (Potochnick & Perreira, 2010). The decision to migrate shows optimism about life and even resilience, but the amount of stress the immigration process produces, the separation from family and friends, the adversity and suffering in the new country, and the cultural expectations can have negative and detrimental effects in the same individual (Marsiglia, Kulis, Garcia Perez & Bermudez-Parsai, 2011; Merz et al., 2011). Research conducted by Heilemann et al. (2004) showed that women who were brought to the U.S. during childhood reported more depressive symptoms than those women who spent their childhood in their country of origin (Mexico) before immigrating to the U.S.; these women reported significantly fewer depressive symptoms. Hispanics tend to seek emotional support from their families and extended families. Professional help is often a last resort (Heilemann & Copeland, 2005).

Hispanic youth (12-18 years of age) constitute 30% of the general Hispanic population. Hispanic youth are at increased risk for anxiety, depression, suicide ideation, and suicide attempts. The economic, social, and political realities in the life of the Hispanic youth reflect their mental health indicators (Garcia, Skay, Sieving, Naughton, & Bearinger, 2008). Anxiety among Hispanic youth has been associated more with parental legal status and depression associated with exposure to discrimination. A rise in both (anxiety and depression) is experienced when youth’s parents are undocumented due to the constant fear of deportation which would cause separation from their parents and rupture the family nucleus (Potochnick & Perreira, 2010). Of particular importance are traditional Hispanic values that emphasize family (including extended family) and community integration, which are different from the Anglo-
dominant values of individualism and self-reliance (Heilemann et al., 2004). This difference may pose psychological distress on the Hispanic youth going through the process of acculturation. Literature provides evidence of Hispanic female youth (especially 9th graders) being an especially vulnerable group, having rates of sadness and hopelessness of up to 39.7% in this group with suicidal ideation of 20.2%, and suicidal plan of 15.4% (compared to non-Hispanic white female rates of 31.1%, 16.1% and 12.3%, respectively; CDC, 2010c). Being a Hispanic youth of mixed ethnicity (Hispanic with non-Hispanic White or Hispanic with African American) increases the complexity and exposure to stress (Garcia et al., 2008). Among Hispanic 9th and 12th graders, those Hispanic-mixed students had higher rates of suicide ideation, suicide attempt and elevated levels of emotional distress than those that were Hispanic-only students (Garcia et al., 2008).

Fatalistic and pessimistic perceptions of life stressors tend to be part of the ideology of Hispanics even from childhood and adolescence. These feelings often result in a sense of lack of control over external situations. Moreover, pessimism is related to an increase in depression (Choi, 2002; Muennich Cowell et al., 2005). This lack of a sense of self-control over external circumstances could be linked to a greater dependence on faith and higher levels of religiosity that could buffer life stressors (Lee, Czaja, & Schulz, 2010).

Among Hispanics, females tend to have higher rates of hopelessness and stress than their male counterparts where, among the general population, males have higher rates of hopelessness than females (Marsiglia et al., 2011). Hispanic females have 73% higher probability of experiencing depression than Hispanic males, although females can feel hopelessness without feeling depressed (Marsiglia et al., 2011). Hispanic women describe depression as sadness, low energy, low productivity, and not taking care of one’s appearance and hygiene (Mann, & Garcia,
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2005) or headache and nerves (Choi, 2002). Hispanics experience and perceive psychiatric disorders more as somatic symptoms or they underreport mental health issues to the providers (O’Connor et al., 2008). Interestingly, a study conducted by Nadeem et al. (2008) shows that increase in somatization (as seen in ethnic minorities) may actually be an adding factor increasing the person’s perceived need for mental health treatment.

Hispanic women from rural areas not only have limited access to care and resources but also have cultural beliefs that discourage them from seeking help for emotional issues, specifically Mexican-American women. Mann and Garcia (2005) identified barriers perceived by Mexican women that prevent them from getting the help they need, including being timid and fear of embarrassment when others learned of their mental condition. Other barriers included the need to keep depression private from their significant others (usually spouses), over-controlling husbands, and undesired side effects from pharmacological treatment (somnolence). Migratory status, lack of daycare, lack of transportation, and long waiting times for appointments were also identified as barriers to help. Pieters and Heilemann (2010) found factors like overly busy schedules, lack of time, putting others’ needs before self, and self-neglect as ways to compensate for being depressed (as they can be distracting factors). The authors suggest that key factors in developing rapport between female Hispanics seeking mental health care and clinicians who provide it include: women helping women (motivator effect based on the input from female figures and the acceptance of it), role modeling (another way of women helping women), flexibility with scheduling appointments and motivational interviewing (which is based on assessing the present barriers to achieved desire changes in one’s life) (Pieters & Heilemann, 2010).
Significance and Implications to Nursing

Advanced practice nurses can improve care to Hispanic populations by adapting the care to the population’s specific characteristics. Hispanics are the fastest and youngest growing minority in the U.S.; they will make up a significant proportion of the future patient population. Hispanics signify a great working force in the economy and their children are a big part of the future of the country. Providing them with the best possible care will improve their lives and will strengthen our nation’s future. In order to maintain a mentally healthy Hispanic population, it is necessary to understand two important concepts. First, it is important to understand how ethnic and cultural differences affect the way Hispanics present (or do not) with complaints of depressive symptoms. The second concept to understand is how practitioners can incorporate these differences in their care to diagnose depression appropriately and initiate treatment according to the characteristics of the person. This will give Hispanics a better chance of recovery. Cultural differences transcend language barriers. Knowing how Hispanics, especially youth and females, manifest symptoms of depression early in life should increase screening rates at an early age, including collecting a detailed family history for depression.

Research has demonstrated that a multidisciplinary approach to depression provides better results for screening, early treatment, following up on treatment outcome, adhesion to treatment, support programs, and even early detection of lack of improvement (CDC Community Guide, 2010). The following are recommendations for practitioners in primary care, and community support entities (churches, schools and community centers). Each intervention is identified according to the community health standards of primary, secondary or tertiary interventions that are gleaned from the literature evidence.
Primary interventions for practitioners include:

- Increase the overall awareness of depression through education and options on mental health care. Educate in areas with high Hispanic population concentration (office and clinic waiting rooms, lobbies of churches and educational centers). The educational material should include mental and emotional signs and symptoms as well as somatic symptoms (headaches, nervousness, low energy, etc.), and where to go for help. It is important to keep in mind the utilization of language aids to overcome language barriers. Practitioners can provide culturally appropriate care by integrating Hispanic ethnic and cultural characteristics into their care, such as language, beliefs, social structure, and education level (Zambrana & Carter-Pokras, 2010).

- Institute programs for prevention of depression in areas with high immigrant populations. Support programs could reinforce the family as a whole, reinforcing the role of family as an important institution for support among Hispanics and a mitigating factor against negative stressors (Farr et al., 2011; Potochnick & Perreira, 2010).

- Use valid, reliable and language appropriate screening tools. The Spanish version of the nine item Patient Health Questionnaire-9 (PHQ-9), has been proven to be a valid and reliable screening tool (88% sensitivity and specificity) in Spanish-speaking populations (Merz et al., 2011). The twenty item Center of Epidemiologic Studies Depression Scale (CES-D) is another community screening tool for depression that has been proven valid and reliable in Spanish (Heilemann et al., 2004).
Secondary interventions for practitioners include:

- Screen Hispanic patients, especially females, for depression and mental symptoms annually in primary care settings. This screening should be conducted in the patient’s preferred language (Farr et al., 2011; Heilemann et al., 2004).

- Start depression screening in adolescence and continue consistently through teen years until at least 18 years of age. The screening should be done annually at the primary care provider (PCP) visits or at the school of attendance with the results shared with the PCP for appropriate intervention and continuation of care (Farr et al., 2011; Maradiegue, 2010; Melnyk et al., 2009).

- Assess individuals by age group to screen and potentially diagnose and treat age-specific developmental differences in depression (Maradiegue, 2010; Melnyk et al., 2009).

- Provide appointment flexibility, transportation aid (including information in Spanish about bus routes and fares), child care (while appointments or therapy last), confidentiality, culturally appropriate professionals, and community resources in clinic settings in order to facilitate access to health care (Marsiglia et al., 2011).

- Reinforce the availability and use of language translation services in the appointments and written educational material in order to provide cultural competent care complying with CLAS standards (U.S. Department of Health and Human Services, 2001).
Tertiary intervention for practitioners include:

- Explore treatment options that include psychotherapy as part of the initial therapeutic approach to depression since the Hispanic population accepts this intervention easily (Farr et al., 2011; Gonzalez et al., 2010).

- Coordinate depression care with other health care personnel, such as case managers, to monitor treatment efficacy and detection of disease worsening in order to institute an appropriate referral system to mitigate the effects of uncontrolled depression (CDC, 2010b).

- Educate family members who provide support to patients that are affected by depression, since it is common among Hispanics to seek emotional support from family members first (Garcia et al., 2008; Heilemann, 2005).

- Provide a safe, therapeutic environment to patients where they will not be concerned about their legal status or potential for deportation. Create an environment where they only concentrate on their mental well-being (Marsiglia et al., 2011; Potochnick & Pereira, 2010).

Primary interventions for teachers and counselors at schools and after school programs:

- Provide children and adolescent peer and teacher support while providing tools for adequate and efficient acculturation (Potochnik & Perreira, 2010).

- Educate teachers and counselors of elementary, middle and high schools, especially those that have high numbers of Hispanic students, about the high incidence of depression, anxiety, emotional distress, acculturation and identity struggles among Hispanic youth. A collaborative approach between the primary care provider, community based organizations and schools should be implemented to provide a
safety net for this population (CDC, 2010b; Garcia et al., 2008; Heilemann et al., 2004).

Primary interventions for the social community (schools, churches, community centers):

- Schools, churches and community centers should institute programs that offer support and education to Hispanic parents (preferably in Spanish) who wish to learn more about building and strengthening relationships with their kids (Garcia et al., 2008). Also, these same centers should create and offer programs to help build the self-esteem and identity of the young Hispanic girls, through counseling, exercise and sport programs, family oriented dances, and potlucks. These programs should be strongly based on the Hispanic cultural values, beliefs, and traditions (Alexandre et al., 2010; Cummings & Druss, 2010; Melnyk et al., 2009).

- Promote the use of mentoring programs for the youth that lack an adequate parent (mother or father) figure. They should reinforce the presence and use of extensive family as part of the family resources to mentor the young Hispanic kids. Advertisement and recruiting should be made of adult Hispanic professionals in the community to serve and get involved in local mentoring programs for the Hispanic youth (Garcia et al., 2008).

- Give support through ‘women helping women’, where women can socialize and share in order to avoid alienation. The use of motivational interviewing and role-modeling done by other women in similar situations (support groups) are techniques proven to increase motivation to enter therapy, therefore giving good results among Hispanic women (Pieters & Heilemann, 2010).
Summary and Recommendations for Future Research

Depression is a condition that is becoming more prevalent; Hispanics are a minority that are increasing in numbers in our country, low income and poverty are increasing in our society, and more and more underserved populations cannot access mental health care. Understanding how depression affects Hispanics, the similarities and differences in the perception of the symptoms, and the population-specific characteristics that could influence outcomes are of great importance for clinical practice. More research is needed to understand the specific treatment approaches for the Hispanic population and their response to them. Pharmacogenomics would be a necessary aspect for research including assessing the response to antidepressants in the Hispanic population. Also, research is needed on the response of the Hispanic population to alternative therapies like: psychological therapy, counseling, support groups, cognitive and behavioral therapy, and the use of home therapies targeting specific needs, in accordance with the recommendations on a collaborative care model provided by the CDC (CDC, 2010b).

Research should continue on the effects immigration has on future generations of U.S.-born Hispanics (not only on first generation Hispanics), how acculturation plays a role in the development or lack of depression, in the resilience of this culture, and the newer generations perception towards the disease.

Lastly, it would be worth examining the impact of interpretation services like language lines and formal or informal interpreters and how the use of these services affects the therapeutic communication between provider and patient.
References


http://www.cdc.gov/nchs/data/hus/hus10.pdf#063


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