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Older Mexican Americans' Perceptions of Mental Distress

Irán Barrera and John Gonzalez

The recognition of mental distress in older Hispanics can be challenging for mental health professionals, as well as for the individual suffering from mental distress and his or her family. Hispanics have often used non-psychiatric terms to describe or label their mental distress. This qualitative study conducted in Texas focused on how older Mexican Americans perceive mental illness, and on how they identify the causes of, and assign labels to, mental distress. This study reveals that older Mexican Americans have several different names for mental distress (i.e., coraje), as well as provides important insights regarding the perceived causes of mental distress. A discussion follows which provides important recommendations directed at enhancing the quality of mental health care for older Mexican Americans.

Kirmayer (171-176) stated that *somatization* refers to the presence of physical symptoms for which there is no diagnosable physical condition. Using the Hispanic Health and Nutrition Examination Survey (H-HANES), a large-scale epidemiological and health survey, Angel and Guarnaccia (1233) found that respondents who had high scores on the Center for Epidemiologic Studies Depression Scale (CESD) rated their health as significantly worse than did the physicians who also rated them. They also reported large differences between Mexican Americans and Puerto Ricans in levels of affective distress; Puerto Ricans reported much higher levels of affective distress and poorer physical health than did Mexican Americans.

Jenkins (319-321) studied Mexican-American families' characterizations of schizophrenia and found families described their family member's schizophrenic symptoms as symptoms of *nervios*. The families also focused on a series of somatic complaints that tended to destigmatize the mental illness. *Nervios* is popularly utilized to refer to a broad and diverse range of distressing emotional states and illness phenomena. In Hispanic cultures, *nervios* is understood as a condition that often affects adults who are experiencing difficult life conditions. Symptoms of *nervios* include; headaches, trembling, heart palpitations, stomach and appetite disturbances, and trouble with concentration, sleep problems, and worrying (Guarnaccia & Farias 1226-1228). Salgado de Synder, de Jesus Diaz-Perez, & Ojeda (467) stated that *nervios*

should be recognized as a “*cry for help*.” It might be a sign of serious mental and physical dysfunction, particularly among those experiencing distress (Salgado de Snyder et al. 467).

The *Diagnostic and Statistical Manual of Mental Disorders*, also known as the *DSM-IV-TR* (APA 897-903) discusses several culture-bound syndromes in the Appendix section. Two idioms of distress listed in the *DSM-IV-TR* that are sometimes recognized in Mexican Americans are *ataque de nervios* and *nervios*. *Ataque de nervios*, reported among Latinos, has symptoms that include uncontrollable shouting, attacks of crying, trembling, verbal and physical aggression, fainting episodes, and suicidal gestures. It frequently occurs because of a stressful life event. Descriptions of *ataque de nervios* are similar to panic attacks and presentations of anxiety, mood, dissociative and somatoform disorders (APA 899-901).

Nervios is another idiom of distress among Hispanics. It includes a wide range of symptoms of emotional distress, somatic disturbance and inability to function. Symptoms include headaches, irritability, sleep difficulties, nervousness, inability to concentrate, trembling and easy tearfulness. It presents like adjustment, anxiety, depressive, dissociative, somatoform, or psychotic disorders depending on the set of symptoms experienced (APA 901). *Ataque de Nervios* and *nervios* are just two conditions from the culture-bound syndromes of the *DSM-IV-TR*. In the Mexican-American community other names and labels are used to describe mental distress not found in the *DSM-IV-TR*. This study explores older Mexican Americans in Texas and their perceptions of mental distress, including the labels, perceived symptoms, and causes.

Conceptual Framework

Kleinman's Explanatory Model (105) is a model often used to examine help-seeking behaviors and culture. According to Kleinman, an explanatory model encompasses the notions a person has about an episode of illness and its treatment delivered by all engaged in the clinical process, based on cultural knowledge and idiosyncratic experiences. Patient, family, and physician each have explanatory models of illness. The explanatory models are informed by the popular culture, the media, health care culture, and the social network. The explanatory models of the illness experience help understand how individuals understand their health needs and decisions about treatment.

Building on Kleinman's Explanatory Model, Green (54-56) adapted Kleinman's explanatory model into a help-seeking behavior model. Green labeled the client explanatory model the *client culture*, and the practitioner explanatory model the *professional subculture*. The client culture includes problem recognition, problem labeling and diagnosis, indigenous help providers, utilization of help providers, and problem resolution. The professional subculture includes professional help providers, minority professionals and professional models. This study uses Green's help-seeking behavior model as a guide for this study in particular, the categories of problem recognition and problem labeling and diagnosis.

Literature Review

Professional Culture

The professional mental health culture consists of its own language, shared values, expressions, thoughts, and traditions. Professionals bring their own culture to the therapeutic relationship. Through education and training, treatment professionals become in a sense bilingual and bicultural. They possess the culture and language from which they come and they learn the culture and language of the profession. Acculturation for the professional culture

comes from education, including medical education and public health training (Angel and Thoits 479-480; Good 436-437; Pelto and Pelto, *Medical Anthropology* 3-4).

Because Western medicine is based on evidence from scientific research it has become the foundation of worldwide health which has in turn influenced the beliefs and the traditions of Western society. Societal institutions that educate and train health care and mental health professionals have been shaped by the dominant American culture and Western medicine. This cultural imprint is at the foundation of training for Mental Health Professionals and they bring this cultural imprint to the clinical setting.

Accurate diagnosis is a trademark of Western medicine (NIH 44-46). Clinicians arrive at accurate diagnosis by determining whether the patient's signs and symptoms significantly impair functioning at home, school, work, and in their communities. Social norms or cultural standards of behavior are the basis for this determination (Scadding 594-596; Pelto and Pelto 152-153). The norms or standards of behavior that clinicians use for diagnosis come from the DSM-IV-TR. When the clinician and the patient come from different cultural backgrounds, the potential for cultural differences in understanding health conditions is greater. Both are actors in the treatment setting. As the DSM-IV-TR puts it,

Diagnostic assessment can be especially challenging when a clinician from one ethnic or cultural group uses the DSM-IV Classification to evaluate an individual from a different ethnic or cultural group. A clinician who is unfamiliar with the nuances of an individual's cultural frame of reference may incorrectly judge as psychopathology those normal variations in behavior, beliefs, or experience that are particular to the individual's culture. (APA xxxiv)

The U.S. health care system now emphasizes culturally sensitive and culturally appropriate health care. Providers have been learning patient perspectives of various cultures. It has been

shown that when practitioners provide culturally sensitive and appropriate care patients' treatment compliance increases. This includes being culturally appropriate and sensitive to the client's acculturation stress, their cultural marginality and in explaining their illness (Stewart 1429-1431).

Views of Mental Illness

The professional culture makes sense of mental illness by using the DSM IV. It addresses culture in the "outline for cultural formation" which includes five characteristics of the cultural context of illness and their significance to diagnosis and care: 1) inquire about patient's cultural identity; 2) cultural explanations of the illness; 3) cultural factors related to the psychosocial environment and levels of functioning; 4) cultural elements in the patient-clinician relationship; and 5) overall cultural assessment for diagnosis and care (APA 897-896).

The Surgeon General report (NIH4-5) provided definitions for mental health, mental illness and mental health problems. *Mental health* was defined as the successful performance of mental function, leading to productive activities, satisfying relationships with other people, and the capacity to adjust to change and to cope with difficulty (4). *Mental illness* refers to as "all mental disorders, which are health conditions characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress and/or impaired functioning" (5). *Mental health problems* are "signs and symptoms of insufficient intensity and duration to meet criteria for any mental disorder" (USDHHS 5). These definitions give meaning to mental health and illness and are part of the vocabulary of the professional culture.

Language and Communication

The language of the professional culture is shaped and oriented by the education received in schools with a foundation of Western medicine. In mental health, communication is key in diagnosis and in treatment. Communication is the method which mental health clinicians

diagnosis symptoms, and their impact on functioning. Because of this emphasis on communication there is potential for miscommunication when the clinician and patient are from different backgrounds. Abramson, Trejo and Lai (22) reported that,

Issues related to the meanings and definitions of health and mental health, attitudes toward illness and disease, and attitudes toward the use of healthcare services, specifically contemporary Western medicine, also have implications for service utilization and for the relationship between the client and therapist. (22)

Language, Spanish in this case, influences the bilingual client's ability to communicate thoughts, feelings, and emotions in English. Language, understanding Spanish, also influences the clinician's understanding of the client's verbal and nonverbal communication (Malgady and Zayas 41).

Limited understanding of the clients' culture by health care professionals can lead to misdiagnosis and inappropriate care (Budman, Lipson, and Meleis 367-368). Professionals face major challenges when confronted with a client with whom they cannot communicate. The challenges include providing diagnostic expertise, building the necessary empathy and rapport, and providing support, comfort, and care (O'Hagan 146). Lago and Thompson (55) believe that the professional's task is to take the responsibility to communicate in a language the client prefers to create an understanding which "evokes trust." O'Hagan (164) discusses two main factors in working with linguistic minorities: first, regard the client's language as significant and important in their daily lives; second, recognize that there is enormous potential for discriminatory practice in the professional's attitude and approach to languages other than their own. Professionals with this awareness of working with linguistic minorities in treatment may experience less denial, fewer delays with service delivery and more accurate assessment.

Research Design

This study consisted of a qualitative exploration of mental health service utilization of older Mexican Americans collected from clients at outpatient mental health programs in Texas. In this ethnographic study the researchers used a purposive sample and interviewed 20 older Mexican Americans 65 years of age or older, who have accessed and completed outpatient mental health services. Selection criteria required that eligible participants: a) completed an outpatient mental health program in the past 12 months; b) experienced a reduction of depressive symptoms; and c) scored 24 or above on the MMSE. The Mini Mental Status Exam is a test of cognitive functioning. The score gives an idea of the patient's cognitive ability for participation in the mental health treatment program. The score also forms part of the assessment and clinical decision, along with completion of clinical goals that the study sites use. The staff administers this test at discharge from the program.

The researchers selected outpatient mental health programs for older adults located in the following Texas cities: Austin, San Marcos, Luling, Seguin, Del Rio, and Cuero. Data collection for this study began in April 2007 and ended in September 2007. The interview schedule was semi-structured with mostly open-ended questions. The interviews took place in the home of the respondent. Given that some or parts of the interviews were conducted in Spanish, the researcher transcribed the interviews into the language originally spoken, English, Spanish, or a combination of each. Transcription took place soon after the interviews. Each interview lasted approximately 45 to 60 minutes and was audio taped with the respondent's consent.

Data Analysis

Ethnographic content analysis was used to analyze the transcripts. Ethnographic content analysis centers on concept development, data collection, and emergent data analysis through repeated study of the content or text (Altheide 68-69). The researchers used Green's

Adapted help-seeking behavior model (54-56) to guide the analysis. Components of Green's model were used in developing initial codes and categories and ultimately themes of the data. As the analysis progressed, the researchers opened other categories, codes and themes, which resulted in identifying older Mexican-Americans' perceptions of mental illness.

Findings

Causes of Mental Distress

When asked "What do you think caused your problem/sickness?" respondents discussed several causes of mental distress. In describing the events surrounding their problem, respondents also described more than one issue that contributed. Along with the perceived cause of their mental distress, respondents also reported other on-going issues like health (diabetes or cardiovascular issues), or family problems (a son in prison or a daughter battling an illness). Respondents experienced multiple issues in their lives, leading them to seek help for their mental distress as described in the following examples of respondents' perceived causes of mental distress.

The perceived causes of mental distress included grief issues, relationship issues, health problems, and physical complaints. Nine respondents reported grief of a loved one—a spouse, sister, or children. Five respondents reported the cause of their distress was a marriage problem—divorce or separation. Two respondents reported health problems—breast cancer, heart attack—as causes of distress. Two respondents reported physical complaints—stomach problems or insomnia—as their cause. One respondent reported financial worries and one reported family problems; her son was in prison.

Grief of a Loved One

One respondent grieved the death of her husband of 53 years. She missed him, and felt sad and alone. Her sons did not live with her; they had their own families, leaving her alone. She had several things on her mind, leading to anxiety. Her leg was hurting, and she was afraid of losing her leg and ending up in a wheelchair. She thought and thought about how she would make it alone.

Bueno, el problema que me condujo al programa fue de que este murió mi esposo.

Entonces me sentía sola y triste porque mis hijos no viven conmigo.

Her body started to hurt all over and she stopped eating. She would cry and cry. She had never had this problem, and did not know about depression. She was not sure if she would get better.

Another respondent's husband passed away after open-heart surgery. She reported that it all happened so fast. He had the heart surgery and looked like he was doing well. The doctor sent him to a nursing home for rehabilitation. While he was in the nursing home, she stayed with him all day and night. Her son paid for the room. Her husband was there for almost two weeks, and she noticed that he was not making progress; he also was not eating well. Her husband developed an infection in his leg, where they took veins for the heart surgery. She decided to spend one night away with some of her friends who invited her to stay at their home.

Cuando regresó al hospital en la mañana, llegó al cuarto y ya se vía fallecido mi esposo. Cuando se fueron todos. Cerré la puerta y de plano que hago sola.

Entonces fue cuando comencé a llorar. Cuando me sentí completamente sola.

When she returned the next morning, her husband had passed away. Everyone left the room, and she started to cry. That was when she felt all alone.

One respondent's sister, the last remaining member of her family, passed away. All of her family had passed on: her parents and all of her brothers and sisters. While she was still

married and had the support of her daughters and sons, she focused on being the last living member of her family.

La falta de mi hermana. Ella falleció y ya me quedé sola. Toda mi familia se murió no mas yo y mi hermana. Ella se me murió mi hermana y la sentí mucho. De atiro me callí muy triste, lloraba mucho y no más me acostaba y me dormía.

She reported growing extremely sad. She would just cry much of the time and she would lie down and sleep. When she would think of her sister, she would roll up like a little ball and cry.

Another respondent talked about losing her son after his long battle with cancer. She had a difficult time coping with his death, even though she had known he was dying. She had difficulty concentrating because of her grieving. She said she felt like she “was not in reality.” She would sleep and cry all day, and could not get over her son’s death. She said, “I couldn’t even say his name.” She went “through all of those steps of denial and anger and asking why, being very unsure of me and crying a lot.” Her physician recommended counseling and sent her to treatment.

Relationship Problems

A problem with relationships was another cause of distress. One respondent talked about having much stress in her life—a daughter who had been ill for several months and problems with her husband. She also talked about having anxiety attacks with her body shaking, something she had never experienced before. She shared that she had tried to hurt herself. Then she had a heart attack. EMS arrived and took her to the hospital. Her daughter-in-law told the paramedics that she had also tried to hurt herself. Once in the hospital, a social worker referred her to the treatment program, and she realized that her problem was “a marriage problem. It is not my children; it’s my husband.” She also shared that she was grateful to her daughter-in-law for telling the paramedics she had tried to hurt herself.

One male respondent talked about his problem separating from his wife. He had been married for 25 years. He decided to move to a new city, a place where one of his daughters lived. He was beginning a new life in a new place and did not have any friends.

Lo que pasó, es que, nos separamos yo y mi señora. Entonces como mi chamaca aquí vive una de ellas me trajeron para acá. (to San Marcos, daughter lives in San Marcos). Y la separación de la señora. Íbamos a completar como veinte y cinco años estar juntos. Eso me tumbó. Cuando vine aquí, pues la renta, el lugar este. No conozco a nadie. Cosas así es que. Pues me callí de atiro.

He felt depressed, very depressed and could not sleep. He did not sleep most of the night. His only support was his daughter and she eventually contacted his doctor and the program.

Health Problems

Some respondents' problems began with a health problem like a heart attack or breast cancer, and then another problem developed in coping with that original problem. One respondent's problem started with a diagnosis of breast cancer. Her husband had difficulty accepting his wife after her mastectomy leading to marital problems. "I got cancer and my husband rejected me." She talked about her marriage changing after her mastectomy. Her husband changed from "the perfect husband, the perfect father, the perfect son-in-law, the perfect brother, he is perfect." Their relationship changed, no socializing, everything felt like it was false to her. He never moved out of the bedroom. She felt depressed and very unhappy. She also considered leaving her husband. She then found help at the program.

Another respondent had a heart attack and felt *coraje*, anger. She was not angry with anyone in particular, just angry that she had had a heart attack, "no tenía coraje con nadie no mas con mi porque me pegó el heart attack." The respondent experienced a big change in her way of living, "porque I was used to myself. I was used to going places." Before the heart attack,

she was taking care of her sister; now her sister was taking care of her. She became dependent on others for help, something new for her.

Behavioral Signs of Distress

Respondents expressed their mental distress, with multiple signs of distress occurring at the same time. Respondents came to the treatment program experiencing multiple signs of depression, anxiety, or both. In the interviews, respondents described experiencing eight behavioral signs of mental distress. The behavioral signs were all similar to symptoms of depression and anxiety. The symptoms that respondents described included depression, anxiety and *nervios*, sleep problems, crying, isolation, lack of energy, appetite problems, loss of interest in activities, and physical complaints. The symptoms that respondents reported, however, centered on depression and anxiety, *nervios*. During the interviews, respondents discussed experiencing multiple symptoms at a time, for example depression, wanting to sleep all day, and crying. All respondents reported experiencing at least two symptoms. Thirteen respondents reported three or more symptoms of distress.

Depression

Thirteen respondents reported the symptoms of depression. One respondent described her depression as thinking of her husband who had passed on. She also was having problems with her leg because of diabetes. Her depression began with symptoms such as appetite problems, crying, and physical complaints.

Entonces no quería comer, lloraba, y me sentía triste tu sabes. Estaba sola. Yo pensaba mucho porque yo creía no iba sobrevivir. Ya empecé con eso que me dolía mucho el cuerpo, no quería comer, llorar. Todo eso lo sentía y todavía no sabía que era depresión.

Her whole body started to hurt. She would not eat; she did not want to eat. She just cried. She was feeling very sad. She did not think that she would survive. She did not know what depression was at the time.

Anxiety, Nervios

Ten respondents talked about anxiety or *nervios*. A respondent reported always suffering from *nervios*. She would suffer from anxiety, not depression. She talked about coping with living alone, her husband having moved to a nursing home. She also talked about her sons not visiting her. In the past year, she thought she was going crazy, and experienced intense anxiety. She talked about walking around her apartment in circles.

A mí me daban los nervios, pero no la depresión. La ansiedad. Y eso no me había dado a mí. A mí me dio con fuerza. Y no sabía yo que era. Por eso yo caminaba y caminaba. Y encerrada aquí. No salía para ninguna parte.

She also mentioned two other symptoms: sleep and appetite problems. She would not stop to eat dinner or lay in bed. She was not sleeping or eating. She would walk and walk around in her apartment. She did not leave her apartment at all.

Sleep Problems

Sleep problems, occurring with depression, were another symptom that respondents experienced with mental distress. Seven respondents talked about sleep problems during the interview. Five of those respondents also talked about depression. One respondent wanted to stay sleeping because of her depression “a mi, mi depresión fue querer estar dormida.” She felt depressed because one of her sons was in prison. She would always think about him. This was her reason for wanting to sleep so much. She would only get out of bed when her other children visited her.

Another respondent, who was grieving her husband, reported having sleep problems, depression, and problems with her arthritis. She thought she had some illness; she did not know what was wrong with her. She did not want to go outside, just wanted to sleep. “Yo creía que era una enfermedad. No quería salir afuera, quería estar dormida. Algo así sentía yo.” She did not think there was a remedy for her condition. She just wanted to stay in bed.

On the other hand, the respondent who had separated from his wife and moved away to begin a new life, reported depression and sleep problems. He would not sleep. He stayed awake all night “no dormía. Me pasaba toda la noche despierto, se me iba el sueño.” He would spend nights thinking about his wife and his new life. He would not get sleepy and spent his nights awake.

Crying

Six respondents talked about the symptom crying, which occurred with depression and anxiety, *nervios*. One respondent would cry and roll up like a little ball, when she thought of her sister that had passed away, “me acostaba como una bolita chiquita. Y me dormía mucho, y ya no sabía que me estaba pasando.” Every time she thought of her sister she would go to her bed, lay down, and just cry. Her husband would tell her not to lie down but she would anyway.

Another respondent that reported depression and crying talked about crying when she would grieve for her husband. She did not know what was happening to her. She had never had this illness and did not know what it was, “nunca vía estado en una enfermedad de esas. No sabía que fuera.” She missed her husband very much.

Isolation

Five respondents talked about the symptom of isolation. Respondents would not leave their home or apartment. Four respondents who reported depression also reported isolation.

Respondents talked about having no desire to go outside or leave their home. Three

respondents who talked about isolation also reported the symptom sleep problems.

Respondents reported isolating themselves from their families and friends. One respondent who was dealing with a recent divorce and complications from diabetes described her isolation.

I am the type, if I start getting depressed, I start shutting the house up. I will stay in my room back there and just don't bother me. I won't answer the phone, I won't answer the door. I would not do anything but stay in my room.

She would lock herself in her room and not talk to her family or friends who would attempt to get her to come out of her room.

No Energy

Four respondents talked about having no or low energy. Two of the four respondents also reported depression and two of the four respondents reported anxiety. One respondent who talked about depression and anxiety had no energy. She talked about the stressors that led to her heart attack—problems with her husband, her daughter battling a long illness. She felt overwhelmed, and did not want to be bothered. She did not have the energy to listen to others or watch television.

I didn't have energy and didn't want to do things. I didn't want anybody to bother me. I would stay in my room and lock the door. I would not hear everything; I would watch TV but not know what they were saying. I would only focus on the light, a small focus.

Appetite Problems

Four respondents talked about having appetite problems, having no desire or will to eat. One respondent who experienced depression because of the loss of her husband talked about such problems. She also experienced crying. She did not want to eat; she would cry and feel sad.

“Entonces no quería comer, lloraba, y me sentía triste tu sabes. Estaba sola.”

Loss of Interest in Activities

Three respondents talked about losing interest in activities, activities such as family time and everyday activities. [Respondents stopped participating in family activities like going to gatherings or family dinners and everyday activities like cooking or hobbies such as reading and watching television.] One respondent described such a loss. She also experienced the symptom of depression due to marriage problems. She stopped doing her regular activities with her family, like shopping and going to dinner.

I just wanted to be just by myself. I didn't think about my children, my brothers or sisters. They would invite me to the store and I would do nothing. "Let's go and eat mom, no, I don't want to go." I was so depressed with myself that I didn't care for nothing.

She would tell her family "no" when invited to dinner or to shop. She had no desire to spend time with her children. She also talked about losing interest in everyday activities like cooking. She had a difficult time coping with depression.

Physical Complaints

Five respondents reported having physical complaints like stomach problems, and head and body aches as symptoms that occurred with depression and anxiety. Three respondents were U.S.-born, and two were immigrants. The respondents that complained of physical complaints had lower education and lower income. One respondent reported stomach problems and depression. She had pain in her chest, close to her heart and stomach.

Oh no, yo en veces traigo una cosa aqui asi (she motions to her chest, below her heart and above her stomach). Como un depressed, como ahorita a las cuatro se iba ir mi hijo. Y me dijo que me iba hablar antes que se fuera por que el bus salía a las cuatro. Y no me habló. Y pues me dio . . . me sentí muy mal.

This would happen when she thought of her son, who had been to prison in the past and was in a substance abuse treatment program. She would pray for him to change his ways.

Another respondent who reported anxiety and crying talked about physical complaints. She would get headaches when she would think of her sister “en veces me dolía la cabeza por que pensaba mucho de ella.” She would spend much of her time thinking about her sister. She was the last member of her family to pass on. She could not forget her.

Applying Illness Names (or Labels)

When asked what name they gave their problem, respondents reported different names. Among the names used for the problem that led them to treatment was depression or *depresión*, anxiety, *nervios* or *ansiosa*, also *coraje*, *soledad*, and *tristeza* (see Table 1).

Table 1

Name of Illness

Depresión – Depression
Ansiosa/Nervios – Anxiety
Tristeza – Extreme Sadness
Soledad – Extreme Loneliness
Insomnio – Insomnia
Coraje – Strong anger held inside which is hard to let go of or get over.

Eight respondents used the name *depression* for their problem, “depression was the best word to use.” One respondent talked about feeling depressed, “yo lo sentía que tenía depresión.” Six respondents used the name *depresión*. Respondents described their depression or *depresión*

using symptoms like having no energy, no desire to interact socially with their family, and wanting to stay in bed and sleep all day.

Three respondents used the term *anxiety*, one used *ansiosa*, nervous, and five used the name *nervios*. Respondents described anxiety or *nervios* as having anxiety attacks, experiencing loss of interest in everyday activities, and having no energy. One respondent shared that she has always had nerves, “yo todo el tiempo a padecido de los nervios.”

One respondent who was grieving her husband called her problem *soledad*, loneliness. Another respondent that lost her sister, her last remaining family member, called her problem *tristeza*, extreme sadness. One male respondent used the name *insomio*, “no, mi problema era no dormir. Falta de sueño. Se le llama insomnio.” He did not use the word depression or *depresión* in the interview. He just reported having problems sleeping.

One respondent called her problem *coraje*. The respondent used the term to mean more than just anger or rage. The anger she described is strong anger held inside, that is hard to let go of or get over. It is more than a feeling of anger. To her *coraje* is something that she has, something she is experiencing. She blamed the *coraje* for her mental distress. The respondent was very angry because she had a heart attack, limiting her independence. This was a big change in her life, “si, un cambio muy grande. Por eso me agarró mucho coraje.” The change was the reason she had so much anger. Her *coraje* grabbed hold of her. She blamed losing her independence on having the heart attack, and could not let go of this anger. Her sister told her she was depressed.

Discussion

Respondents in this study had many perceptions of the causes of mental distress and also of the behavioral signs of mental distress. Many respondents were not aware of their mental distress until their physician explained it to them. At times, respondents somatized their mental

distress, particularly because they did not understand what was happening to them.

Respondents experienced a multiplicity of issues. Along with the cause of their mental distress, respondents also had other on-going issues like health problems, diabetes or cardiovascular problems, or family problems like a son in prison or a daughter that was battling an illness. Respondents also reported several names or labels with regard to mental distress.

The causes of mental distress included marriage problems, separation, divorce, family problems, health problems, and financial problems. The behavioral signs reported were similar to symptoms of depression and anxiety (sleep problems, crying, isolation, lack of energy, appetite problems, loss of interest in activities, and physical complaints). These behavioral signs were also similar to Guarnaccia, Rivera, Franco, and Neighbors' (354-359) study of *ataques de nervios* in Puerto Ricans and other Latinos. They found that *ataques de nervios* consists of a sense of loss of control, a threat to social order, emotions of sadness and anger, expressions of distress in the form of physical symptoms, aggressive outbursts, and loss of consciousness.

Among the names or labels used for the problem that led respondents to treatment were depression or *depresión*, anxiety, *nervios* or *ansiosa*, also *soledad*, *tristeza* and *coraje*. Respondents reported some terms not included in the Cultural Bound Syndrome section of the DSM-IV-TR. At times, the language or names of illness respondents used had multiple meanings. Respondents had difficulty with their mental distress because of the loss of independence due to aging. Accepting the fact that they had grown old was taxing for respondents. They have had control of their lives for years and now rely on their children or spouse to meet their needs. Many of the respondents were females who had taken care of their spouse and children with some working full-time jobs. Relying on others and accepting help also contributed to their mental distress. Respondents had trouble moving out of a caregiving role to a care receiving role.

Recommendations

As older Latinos turn to mental health services, they often face several problems in the environment, including language and cultural distance. In order to decrease this cultural distance, the social worker needs to take into account the factors that contribute to distancing, building an understanding of what is associated with cultural distance for each client and performing accurate assessments. The recommendations include expanding the workforce of bilingual/bicultural providers and Spanish speaking providers; providing community education of mental illness to older adults and families; and supplying information to help reduce the stigma of mental illness and the cultural distance between older Hispanics and health care providers.

Communication

A recommendation to listen to the meaning of the language spoken will help older Latinos and improve the communication between older Latinos and social workers and other health care providers. Social workers providing treatment to older Latinos also need to understand the mechanisms of cultural distancing among themselves to treat older Latinos effectively. Mental health providers need to offer services in Spanish, which is the primary language for some older Hispanics. To provide services in Spanish the workforce of Spanish speaking or bilingual/bicultural providers needs to increase. To do this we need to recruit bilingual/bicultural students to become health care providers. We also need to recruit students who are Spanish speaking, or encourage students to learn the Spanish language.

Communication is influenced by language, in this case speaking Spanish. This influences the bilingual client's ability to communicate thoughts, feelings, and emotions. Speaking and understanding Spanish also influences the clinician's understanding of the client's verbal and nonverbal communication.

Education of mental illness and treatment services for older Latinos and their families

Another recommendation for social work and health care providers is to supply better information on mental illness and services to older Latinos and their adult children and families. Providing this kind of education will help increase the understanding of mental illness and mental health services. For example, older Latinos and their families need education concerning the insurance benefits for which they qualify for mental health services, plus general information about mental health.

There is a need is to reduce the stigma of mental illness and mental health treatment. To do this, we need to provide community education on mental illness and mental health services. There exists confusion of what mental illness is. In the case of older adults, ageism, the tendency to discriminate against or stereotype older adults adds to this confusion. The current older adults grew up thinking that having mental illness meant, “I am crazy.” Today, we understand that mental illness is a part of life. At times in our lives we need help with transitions, particularly the transitions that come with getting older, like the death of a spouse or change in health condition. Targeting the children of older adults will help reduce the stigma of mental illness and provide the opportunity to educate the community about mental illness and mental health services.

Addressing Cultural Distance

With the current population growth, the barriers faced by, and needs of, older Latinos will need ongoing assessment. Helping older Latinos identify the barriers they are experiencing is vital to these assessments. Older Latinos might not identify a challenge as a barrier. In working with older Latinos, social workers need to consider the degrees of acculturation, language skill and preference, as well as adherence to traditional customs, values, and norms of those being treated (Santiago-Rivera 14-15).

Professionals need to move beyond holding a simplistic view of culture (i.e., creating a physical atmosphere and hiring people who speak the language); to one that incorporates the multiple dimensions of culture in a more detailed way (Bernal and Castro 801-803). For social work professionals, some suggestions for moving beyond a simplistic view of culture include cultural competency training focused on the language and culture of the region. Professionals need to understand and learn that Spanish exists in different dialects, that Latinos come from different countries, and that Latinos have lived different lifestyles and have different life experiences. Understanding the language that older Latinos are using will improve services for both the professional and the patient.

To decrease this cultural distance, planners need to take into account both factors of the linguistic minority clients and the factors of the professionals who will be working with them. Professionals need to understand factors of cultural distance for each individual client, and to provide accurate assessments. Professionals providing treatment to linguistic minorities need to understand these considerations among themselves to do so effectively. In a pilot study, Choi and Gonzalez (128-129) found contributors to accessing mental health services for older minorities included physician social worker referrals, churches, former patients, and community outreach. They also noted that having a supportive family, and the treatment agency having bilingual/bicultural clinicians contributed to better access to mental health services (Choi and Gonzalez 29-130).

In social work, we are taught to meet the client where they are. In working with older Mexican Americans, there are times where there exists much cultural distance between the service provider and the client. Incorporating the values of *personalismo*, *respeto*, and *familismo* into services can help decrease this distance. For example, one thing to do for an older Mexican American who has limited command of English is to translate keywords of the topic that is

presented. This helps the older Mexican American feel respected because the staff took the time to personalize services. This type of service helped respondents commit to the treatment services. *Familismo* is significant in the culture for older Mexican Americans. When they find services that are family-like, adherence to prescriptions and treatment recommendations will be more likely. Adding the values of *personalismo* and *respeto* to practice makes services feel like family. The services also feel less like Western medicine and more like something traditional or something that the older Mexican American is used to.

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