

In any given year, 10-14 million people experience a clinical depression; women ages 18-45 account for the largest proportion of this group. Latinas may be at an increased risk: They experience depression at roughly twice the rate of Latinos (National Institute of Mental Health, 2000) and they are more likely to experience depression than Caucasian or African American women. (Shattell, et al.) According to a report by the Centers for Disease Control, Latina teenagers in the United States are the group most likely to seriously consider suicide, which is associated with depression.

What is depression?

Clinical depression is a serious medical illness that is much more than temporarily feeling sad or blue. It involves disturbances in mood, concentration, sleep, activity level, interests, appetite and social behavior. Although depression is highly treatable, it is frequently a life-long condition in which periods of wellness alternate with recurrences of illness.

What are the symptoms of major depression?

The onset of the first episode of major depression may not be obvious if it is gradual or mild. The symptoms of major depression characteristically represent a significant change from how a person functioned before the illness. The symptoms of depression include:

- persistently sad or irritable mood;
- pronounced changes in sleep, appetite and energy;
- difficulty thinking, concentrating and remembering
- physical slowing or agitation;
- lack of interest in or pleasure from activities that were once enjoyed;
- feelings of guilt, worthlessness, hopelessness and helplessness;
- recurrent thoughts of death or suicide; and
- persistent physical symptoms that do not respond to treatment, such as headaches, digestive disorders and chronic pain.
- Latinas may be likely to complain of “nerves,” “brain ache,” “brain exploding” or “heartache.” (Vranich; Petit, 2003)

When several of these symptoms occur at the same time, last longer than two weeks and interfere with ordinary functioning, a clinical depression is likely and a professional assessment is needed.

What are the risk factors for Latina women?

Women who immigrated recently to the United States and have to adjust to a new culture are more likely to have major depression than other women. Lack of acculturation, or adjustment to the new culture, may lead to problems because of issues like self-esteem and stress. High levels of acculturation among immigrants may lead to internalizing, or accepting, stereotypes (Vranich; Petit, 2003). According to the U.S. Census Bureau, 21.5 percent of Latinos live below the federal poverty line, compared with 8.2 percent of Caucasian Americans. (DeNavas-Walt, Proctor, Smith, 2005) Poverty contributes to the higher rates of depressive symptoms. Sadly, only 21 percent of Latina women seek mental health help and/or treatment.

Other risk factors may include racial/ethnic discrimination, low-status and high-stress jobs, unemployment, poor health, larger family sizes, divorce or separation and single parenthood. Strong feelings of perceived and real prejudice as part of ethnic family cultures also play a role. The emotional strain of caring for elderly parents can also be a risk factor for depression in Latinas. (Vranich; Petit, 2003)

What are the causes of major depression?

There is no single cause of major depression. Psychological, biological and environmental factors may all contribute to its development. Whatever the specific causes of depression, scientific research has firmly established that major depression is a biological, medical illness. There is also an increased risk for developing depression when there is a family history of the illness.

How is major depression treated?

Although major depression can be a devastating illness, it is highly treatable. Between 80-90 percent of those diagnosed with major depression can be effectively treated and return to their usual daily activities and feelings. Many types of treatment are available, and the type chosen depends on the individual and the severity and patterns of his or her illness. There are three well-established types of treatment for depression: medications, psychotherapy and electroconvulsive therapy (ECT). For people who

have a seasonal component to their depression, light therapy may be useful. Transcranial Magnetic Stimulation (TMS) may be useful for mild to moderate depression that has not responded to one trial of an antidepressant. These treatments may be used alone or in combination. Additionally, peer education and support can promote recovery. Attention to lifestyle, including diet, exercise and smoking cessation can result in better health, including mental health.

Medication

Research has shown that imbalances in neurotransmitters, or chemicals in the brain like serotonin, dopamine and norepinephrine can be corrected with antidepressants. It often takes two to four 4 weeks for antidepressants to start having an effect, and six to 12 weeks for antidepressants to take full effect.

Individuals living with mental illness and their families must be cautious during the early stages of medication treatment because normal energy levels and the ability to take action often return before mood improves. At this time—when decisions are easier to make, but depression is still severe—the risk of suicide may temporarily increase.

Psychotherapy

There are several types of psychotherapy that have been shown to be effective for depression, including cognitive-behavioral therapy (CBT) and interpersonal therapy (IPT). CBT concentrates on changing the negative attributional bias (seeing every cup as half-empty) associated with major depression. The focus in IPT is on a patient's relationships with peers and family members and the way they see themselves. Research has shown that mild to moderate depression can often be treated successfully with either of these therapies used alone. However, severe depression appears more likely to respond to a combination of psychotherapy and medication.

For many Latinas, the faith community is often an important source of support. It should be integrated into any care plan for a person who participates in such a community. In some cases, pastoral counseling will be a beneficial part of a comprehensive treatment program.

What are the barriers to treatment for Latina women?

Less than one in 11 Latinos with mental disorders contact mental health specialists, and less than one in five contact primary care providers. (Surgeon General, 2001) In a study of the quality of care for depression and anxiety disorders, it was found that only 24 percent of Latinos received appropriate mental health care, compared with 34 percent of Caucasians. (Young, et al., 2001)

Latinas tend to underutilize mental health clinics for their emotional problems because of few, accessible, culturally appropriate and affordable services. (Organista, 1995; Organista and Muñoz, 1996) So instead of using the appropriate mental health services, many use medical clinics for mental health issues.

The value that Latinas place on privacy is another barrier to treatment. Mental illness may also have a stigma attached to it, and Latinas don't want to be viewed as "loca." They may also attach a stigma to taking medication.

They may feel that the problem is of divine making, so they may prefer to look for spiritual (e.g., clergy or spiritist) treatment when physicians mention nonphysical problems. (Garcia-Preto, 1996) While belief in spiritual healing is important, it is best used in combination with other treatments like therapy and medication.

What are special treatment considerations for Latina women?

Latinos are at higher risk for certain medical illnesses, including diabetes, hypertension, AIDS in women and tuberculosis, so health care professionals should be extra careful to ensure medications will not react with medications already being taken.

Use of over-the-counter and holistic remedies are widespread in this population. Latinas should inform doctors of everything that they are taking—even if it is not a prescription medication—because of possible drug interactions.

Latinas may also be more likely to find therapy useful and less likely to find medication useful because of personal beliefs.

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