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Feature Article

Coping with mental health issues among older Hispanic adults

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ABSTRACT

Access to mental health services for older Hispanic adults is limited and often older Hispanic adults must rely on their own resources in dealing with mental health issues. The aim of this study was to understand how older Hispanic immigrants cope mental health issues (e.g. stress, anxiety, and/or depression). A qualitative, descriptive approach was used to interview 17 older Hispanic immigrants from Guatemala, Dominican Republic and Colombia. Interviews were audio recorded, transcribed and translated verbatim by bilingual research assistants. Data were analyzed using content analysis with a combination of immersion/crystallization, editing and template organizing styles. Ways of coping included spiritual beliefs and religious practices, social support, distraction, medications and professional help. Primary care providers may be more effective if they build upon the cultural constructs that undergird older Hispanic immigrants' ways of coping in addressing emotional distress and mental health issues in this population.

Introduction

The growth of the Hispanic population has reached a historical high in the United States (U.S.) when compared to other minority groups. Hispanic older adults will account for a considerably larger portion of the Hispanic population and a significant segment of the general U.S. population. It is projected that by 2050, Hispanics will account for 19.8% of the older population in the U.S. Despite the rapid growth in the Hispanic population and the number of efforts to reduce health care disparities, Hispanic older adults continue to face substantial challenges, even more so under the current political environment.[1–5]

Mental health illnesses and physical disabilities are closely associated. Older adults with mental health issues have poorer health and social outcomes and higher rates of hospitalization and emergency room visits.[6,7] Conversely, chronic illnesses can impact older adults' mental health and pose challenges for older adults' participation in treatment regimens.[8] The most common mental health issues faced by older adults include depression, anxiety, neurocognitive disorders, such as Alzheimer's disease and other dementias, suicide and alcoholism.[9–11]

Prevalence rates for depression alone among older Hispanic adults living in the U.S range from 13% to 35%.[12] In spite of this, researchers continue to show that Hispanics have very low rates of mental health service use.[1,13] Furthermore Hispanic immigrants are even less likely to use mental health services than U.S. born Hispanic adults.[14,15]

When older Hispanic adults seek care for mental health issues, they often seek care in the primary care sector. Primary care providers, nurses and other health care professionals tend to focus on the standard assessment and treatment protocols and less on understanding culturally-based ways of coping. Furthermore few nurse researchers have focused on understanding how older Hispanic immigrants cope with the psychological and emotional stress of extreme life events before, during, and after immigration where mental health resources were limited and often non-existent.[12] In order to design meaningful and effective mental health interventions, nurses need to have a greater understanding of how this population copes with mental health issues. The aim of this study is to understand how older Hispanic adults who have migrated from Guatemala, Dominican Republic and Columbia, living in a low income community cope with the mental health issues of stress, anxiety and depression.

Method

An inductive, qualitative, descriptive research design, including interviews with seventeen Hispanic older adults, was used to address the following questions.

1. How do older Hispanic adults who have migrated to the U.S. cope and/or think one should cope with mental health issues?

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2. How do these relate specifically to stress, anxiety and/or depression?

Recruitment

The participants were recruited from a free clinic for uninsured residents of a low income, urban, predominantly Hispanic, community in New England. Flyers in Spanish and English were posted at the clinic which noted that participants needed to be 65 years of age and of Hispanic origin. A monetary incentive of a 25 dollar gift card for participation in the study was also offered. Initially two participants were recruited from the posting of the flyers. Using a snowballing sampling approach[16–18] additional participants were recruited for the study.

The Institutional Review Board at the respective University granted human subjects approval for the study. An initial phone contact was made with each participant in order to schedule a home visit to obtain informed consent and conduct the interview. All participants who were contacted participated in the study. During data collection and analysis, an initial sense of data saturation was noted at the fifth to sixth participant, however not until the inclusion of the sixteenth and seventeenth participant were similar responses consistently surfacing.

Participants

In terms of sociodemographic data, all of the participants entered the United States as adults anywhere from four to 39 years ago, with it being over 20 years for the majority. Eight were from the Dominican Republic, five from Columbia and four from Guatemala. There were 11 women and six men who ranged in age from 65 to 83 years, with nine having had some elementary education, three having been to high school and two having college degrees. The majority of the participants described extreme life events as reasons for migrating including destruction of homes and lives due to drug trafficking and civil war, severe poverty and abuse from alcoholic fathers or husbands.

Data collection and analysis

An initial interview lasting from one to two hours was conducted in each participant's home by bilingual research assistants. In a second interview, the research assistants checked for the accuracy and comprehensiveness of the transcript with each participant. Additionally, further clarification of inconsistencies and additional data were gathered. A semi-structured interview guide was used to gain an understanding of how Hispanic older adults cope with potential and acute mental health issues in general and specifically in regards to stress, anxiety and depression.[19] The interview began with a general question about the participant's life growing up in his or her country of origin in order to gain an initial understanding of the sociocultural context in which ideas about coping with mental health often are formed. This was followed by a series of open ended questions and follow up probes on the participant's beliefs about how people ideally should respond to mental illness and then how any people they have known (themselves included) have coped with mental health issues in general and specifically in relation to stress, anxiety and depression (See Table 1, for examples). The interviews were digitally recorded, transcribed and translated verbatim by bilingual research assistants.

Table 1
Participants' beliefs on how they cope with mental health issues: questions and probes.

Questions	Probes
Can you tell me what it is that people do for mental health problems?	What do people do when they have stress? What do people do when they have anxiety? What do people do when they have depression?
If you had a friend with a mental health problem, what are some of the things you would tell them to become better?	If it were stress? anxiety? depression?
What did you do to cope with stress, anxiety or depression?	Did you do anything to try and get better? What are some of the things that helped?

Interviewers received 12 h of training and practice in recruiting, interviewing and transcribing and were closely supervised during the interview and transcription of audio recordings. The interviewers shared a similar ethnic background with the participants. Additionally the interviewers were often familiar with the culture and Spanish dialect of the participants. All participants chose to be interviewed in Spanish. The interviewers used a series of techniques for interviewing older adults recommended by Domarad and Buschmann.[20] These included the wording of questions in a non-judgmental way, providing positive reinforcement, giving the participants control, allowing time and adapting to hearing impairments in order to enhance the credibility of the interview data.

The interviews were content analyzed in a series of three steps using immersion/crystallization, editing and template organizing styles.[21–23] The first step, immersion and crystallization, involved an initial reading and immersion in the interviews in order to illuminate any emergent insights related to how the participants coped or thought one should cope with potential mental health issues. It was during this step that it became apparent that the participants were generally describing "ways of coping" rather than deliberate, intentional strategies that one may use to cope. In the second step, the editing level of analysis allowed for the identification and grouping of "ways of coping" into categories (e.g., spiritual beliefs and religious practices). In the final step, the template analysis, the data in each category were analyzed separately in regard to stress, anxiety and depression, codes that were specified ahead of time in the second research question.

In each of the above steps, each researcher began by reading and analyzing each individual interview and completing an initial cross case analysis and then the researchers met multiple times to discuss and complete the analysis and confirm the findings.

In 1985, Lincoln and Guba[24] developed one of the most well established set of criteria for evaluating the quality of qualitative research. This included four criteria: credibility, dependability, transferability and confirmability. Credibility ensures that the phenomenon was accurately identified and described. In this study, three activities were used to enhance credibility: prolonged engagement, audio recording, back to back translation, and verbatim transcription. Dependability is the attempt by the researcher to account for multiple and changing conditions. In this study, interviews were conducted until data saturation occurred. Confirmability refers to the extent to which the data represent accurately the information participants provided and the findings reflect the participants' voices. This was enhanced by using member checks and multiple quotations in the findings. Finally, transferability demonstrates the application of the findings from this study to the older adult population. In this study an effort was made to provide sufficient detail so the reader can evaluate the potential applicability across geriatric settings.

Findings

The majority of participants openly shared their beliefs and their experiences and/or those of their family and friends with coping with mental health issues. Their ways of coping ranged from their spiritual beliefs and religious practices to social support, distraction, medications and professional help. Table 2 provides an example reflecting each of the four ways of coping.

Table 2
Participants' ways of coping with stress, anxiety and depression.

Ways of coping	Description	Findings
Spiritual beliefs and religious practices	Reference to their reliance on God. In some cases it was though their faith in God was their primary way to cope.	"...At this point of my life I put myself in the Lord's hands."
Social support	Reference to family and/or friends with the support varied from mild, relatively casual to critical in dealing with anxiety, stress and/or depression.	"...Right now I live nears some friends and we go out and eat and hang out outside. We go on the porch and stay there until it's time for bed."
Distraction	Refers to cognitive and behavioral activities helps the individual to focus on something else.	"...you have to cooperate with yourself;" and "...try to distract oneself... try to think about good things. Not negative things."
Medicine and professional help	Refers to antidepressant or anxiolytic medications and/or therapist/psychiatrist.	"... I need to have my pills and if I don't take them I can't sleep and I feel like death ... you can't control mental illness unless you take pills."

Spiritual beliefs and religious practices

During the interviews, almost half of the participants specifically referred to their reliance on God as a way of coping. In some cases it was as though their faith in God was their primary way to cope. One of the participants stated, "Yes, He (God) helped me through everything. I always pray and hold on to Him. It's the only one." Another also saw God as central in coping with mental health issues. He stated,

> There is this saying I go by, 'In bad times always keep a good face and always give thanks to God for everything, the good and the bad.' Everything is in His wish and He has a reason behind it.

When one participant was asked how she dealt with stress, she replied,

> Speaking to the Lord and a lot of prayer... To me mental illness is not really an illness. I believe that it is a lack of connection with the Lord... it's a lack of communication with the Lord... it is spiritual.

Another stated,

> I was able to come out... well I had an emotional problem, lack of forgiveness. I asked the Lord to help me forgive this person that had hurt me years ago; the person didn't even know me. I went to the person and asked for forgiveness and I forgave. At that moment I was able to stand and live again. My self-esteem increased, it was all better after that. Through that particular depression was how I got to have an encounter with the Lord.

Paradoxically, for five of the participants, God was the cause of the mental illness as well as their coping mechanism. It's as though God meant it to be and God will get me out of this. For example, a female participant shared,

> ... when my husband became ill, not knowing what was wrong with him caused me anxiety. I would say to myself 'Why God, why is this happening?' ... At this point of my life I also put myself in the Lord's hands. I know that everything happens for a reason and I cannot be upset at the Lord's decisions. I would go to church very often, this would help me.

A couple of the participants spoke of a supernatural being causing the mental illness. For one it was God, "My mentality has always been that if God let this happen, it is for a reason... He is the one that knows." For another it was a demon, "... it is a demon, which takes possession of the person's mind, because schizophrenia is mental."

Social support

Social support was a powerful way of coping even though it varied from mild, relatively casual to critical in dealing with stress, anxiety and/or depression for participants. Sources of social support included family and/or friends. The participants talked about social support in general like the husband who said, "My wife and kids were a great help." A response specific to stress was, "... you can just hang out with your friends. This can help out greatly, by disconnecting yourself."

One participant who talked about social support for coping with depression commented:

> I visit my children and friends. Right now I live near some friends and we go out and eat and hang out outside. We go on the porch and stay there until it's time for bed. From like five o'clock to seven o'clock pm we're usually outside hanging out and that makes me feel good.

Another participant stated, "I got out of my depression because of my kids, friends and family who supported me." One participant discussed the decision not to take her own life due to her son's words:

> 'Have you thought about the pain and shame you would bring to our family if you did that? I love you mom, you are my everything, but I would be so ashamed if you did a cowardly thing like that. It would shame me so much that I would try to take you out of my heart.' Those words would come to my mind while I stood at that bridge and made me walk away and I'd say to myself 'for you my son I won't do it.'

Distraction

Distraction was another mechanism utilized by the participants to "get through" issues with mental health issues. Distractions used can be differentiated as cognitive/mental or behavioral/activities to cope with stress, anxiety and/or depression. Some cognitive/mental ways of coping included disconnecting self from the "problem," and being positive. Cognitive/mental distractions were suggested as a way to get through anxiety. For example as one participant stated, "... it's a personal situation to you, you have to cooperate with yourself;" and

"... try to distract oneself... try to think about good things. Not negative things."

Similarly participants suggested these ways for dealing with stress. One participant recommended that "... the person suffering from stress needs to leave and disconnect, to release this pressure." Another suggested that stress was addressed by forgetting for a while about what's happening in your life: "I have to get up and go out and leave the house. I do my chores in the house. I tell myself, 'I'm not doing anything sitting down here.' So I get up and start cleaning the house." When asked, what are things that can be done to reduce or make your stress go away?, one participant replied,

> In order to make your stress go away, the best thing you can do is disconnect from the stressful situation; for example, if you are stressed at work you can take a vacation because you are feeling so stressed out. This is a way for you to release that pressure you feel when you are stressed out. You can also go to the movies or a resort; you can just hang out with your friends. This can help out greatly, by disconnecting yourself ... this is why the person suffering from stress needs to leave and disconnect, to release this pressure.

More than half of the participants also recommended or used distraction to deal with depression. One participated stated, "If you don't toughen up you can fall apart." Another suggested, "To keep the mind busy is good." Some other participants suggested: "It is also very important to think about other things, not only about the sadness and the depression;" "The only thing that can help is to find the positive, and accept what has already happened;" "Distraction inspires hope." Another female participant stated,

> My spirit is very positive and very happy all the time, nothing about being sad. I think depression is related greatly with being sad and negative. If you're sad you become depressed. There is this saying I go by, 'In bad times always keep a good face.' You can't let yourself down.

The behavioral ways to cope were often described as activities to distract yourself. One participant described,

> I go out... There are a group of older adults. There we spend time and play bingo. We do exercises. There I distract myself a lot. You have to find a way to not become too closed (shut off), because this is what causes anxiety.

One participant suggested that when she is stressed she "... get up and go out and leave the house. I do my chores in the house. I tell myself, 'I'm not doing anything sitting down here.' So I get up and start cleaning the house." Another suggested,

> In order to make your stress go away, the best thing you can do is disconnect from the stressful situation; for example if you are stressed at work you can take a vacation because you are feeling so stressed out. This is a way for you to release that pressure you feel when you are stressed out. You can also go to the movies or a resort; you can just hang out with your friends. This can help out greatly, by disconnecting yourself.

Several participants suggested cognitive and behavioral distraction to deal specifically with depression. For example, one participant stated,

> You have to keep your mind off the problems. You should go out and walk around. Go to the mall. Go to the park and read. That helps you forget the problems a bit.

Another suggested, "You can't let yourself down. I had three kids at the time and they were very young. You have to move forward... don't let it get to you. Stay active..." While one woman participant stated "... Entertain myself with things, I start to sew, or do something in the house. I clean, organize the house. I paint, or do projects. It is very important to remain occupied." Still another suggested that "To keep the mind busy is good." One participant gave this advice, "... not to let depression and sadness get to them. I would tell them to get up and stay active and that will help them forget."

Medications and professional help

A third of the participants also acknowledged the importance of medications for persons with severe anxiety, depression and other mental illnesses. In regards to anxiety, one woman described how, "I feel like eating. I need to have my pills and if I don't take them I can't sleep and I feel like death... you can't control mental illness unless you take pills."

One male participant stated,

> Depression is a state of negative mood that a lot of times needs to be treated with medication. I personally experienced depression in 1993. I had a "stroke" and got very depressed, but with medicine it was treated.

One woman recognized that medications helped her, but she did not like taking them. Once feeling better, she stopped the medications and did not tell the psychiatrist:

> ... The doctors told me I couldn't stop the medication and I even went to a psychiatrist. I lied to the doctor and told him I was continuing the medication when I wasn't. I was taking the medication on and off. The days I didn't take the medication I felt nervous. And I continued that way for a long time. But now it's been years since then. Here I can go to the doctors and get medications. If I were in Dominican Republic I wouldn't be alive right now.

A few of the participants accepted professional help like the woman above and another female participant who spoke of her sessions with a psychologist, "... I would talk and talk to him, and well never did I take a pill. He would tell me to write..." and her participation in a support group,

> ... I went there, in this big conference room, with students, boys and girls, who were studying psychology... and if you wanted to talk and tell your story you would say it. I would not say anything about my daughter.

According to a male participant,

> A person that is depressed needs to be seen by a psychologist and a psychiatric, professional help... They are two fundamental treatments, going to the psychologist or being seen by a psychiatric doctor. Psychology has been effective and can take a person out of depression.

He continued to comment on mental illness, "There are medical treatments and psychiatrists which are the people who deal with

mental illness. Sometimes they can be cured and sometimes they relapse. When cured or become better they are never the same, they are quiet."

In summary the older Hispanic adults demonstrated their strength through their ability to find ways of coping in the face of poverty, adverse life events, language challenges and immigration. Other than professional help and medications, they coped by socially connecting with others including friends and family, drawing on their spiritual beliefs and distracting themselves. The participants were able to use medical resources such as medications and professional mental health only when they felt they were needed.

Discussion

Like many of the researchers in the literature, we began with the assumption that there is a need for professional mental health services for older Hispanic immigrants and the vulnerability of this population. The most striking finding however was the participants' strength when they were faced with adversity. This is similar to researchers who have indicated the strengths and resiliency of immigrants and immigrant communities.[25] In fact, Whitley et al.[26] have argued that people who immigrate may be especially resilient, and thus less vulnerable to mental health issues. They suggested that immigrants are more likely to belong to close-knit families, tight ethnic communities and religious groups which can provide social support and a sense of belonging, both of which are known to protect mental health. Nurses need to identify existing sources of support for older Hispanic adults, such as religious and social networks in which the older immigrant engages in supportive activities.

The participants' description of spiritual and family supports used to cope with mental health issues are consistent with previous studies[14,15,27] suggesting the centrality of spirituality and family in the daily life of older Hispanic adults. Spiritual coping has been associated with lowered levels of stress and depression.[28] Similarly, Lerman and colleagues[29] found that there was a higher likelihood of depressive and/or anxiety symptomatology among Hispanic older adults reporting no religious affiliation or that religion/spirituality was "not important" in their daily lives. In Harrison and colleagues' review,[30] the authors noted that religious persons give meaning and purpose to adversity which helps them make sense of these events and is a major resource when struggling with illness or other adverse events. Furthermore Stanley et al.[31] in a study of older adults in general found that they preferred religion and/or spirituality integrated within their treatment of anxiety and depression. Primary care providers, nurses and other health professionals need to assess older immigrants' spirituality especially in relation to understanding stressful events.

As noted earlier, family is a major support for older adults. *Familismo* refers to the strong sense of collectivism and family orientation of older Hispanic adults.[32,33] Beyene et al.[34] reported that Hispanic older adults' feelings of well-being were influenced by their family connectedness. In Martinez-Tyson and colleagues' study[15] of Hispanic adults' perception of depression, they found that support from family and friends was vital in coping with depression, and for some a motivating factor in seeking professional care. Controversies do exist in regards to the erosion of familial networks among older Hispanic immigrants as a result of economic, structural and cultural changes in transitioning to the U.S. and its impact on the health and well-being among older Hispanic adults. Often the erosion of familial networks has contributed to the sense of loneliness and isolation described by some older Hispanic adults leading to depression.[35–37] Nurses across all health care settings could have an instrumental role in developing innovative programs in which Spanish speaking, health navigants, community workers, and/or volunteers work with at risk older immigrants in engaging in social activities and support. Other programs such as the shared medical appointments may provide support around chronic disease management.

Other ways of coping among the participants noted above included behavioral and cognitive distraction. These ways may be aligned with cultural constructs noted by Anez and colleagues.[32] They refer to *controlarse* (self-control of negative affects), *aguantarse* (the ability to bear stressful events), and *sobreponerse* (suppression and overcoming challenges) as important culturally embedded constructs to consider when assessing Hispanic adults. In a younger cohort comparing Mexican citizens, Mexican-Americans and non-Hispanic whites, Farley et al.[38] noted that denial, self-distraction and behavioral disengagement were associated with higher levels of perceived stress, and not successful ways of coping unless the perceived stress is addressed directly. These studies highlight a major issue that needs further study: When do culturally based ways of coping provide an effective way to deal with mental health issues and when do they become an impediment to accessing professional care?

Lastly, similar to Jimenez et al.[35] study of ethnically diverse older adults, the participants in this study clearly described depression as a challenging illness and one needing professional treatment. At least half of the participants in this study did not oppose the use of psychotropic medications or psychotherapy for the treatment of depression and/or anxiety compared to other studies' which found the use of psychotropic medications a less favorable treatment modality.[14,39,18] Nurses need to encourage older immigrants to consider medication treatment and/or consultation with a behavioral health specialist if recommended. Nurses can be instrumental in providing education regarding the benefits to treatment options for mental health issues.

Primary care providers in our community and many communities across the U.S. provide the majority of mental health services. Byers et al.[6] argue that older Hispanics may not access mental health care, unless they have a medical illness, since this is often their entry into the health care system. Therefore primary care providers need to learn to engage Hispanic patients in a culturally appropriate way in order to decrease stigma and improve patient engagement in mental health services.[32,39] Most of the traditional treatment modalities in primary care are culturally bound and derived from a western, biomedical model. Several researchers[27,32,39] have argued that the inclusion of cultural constructs of *familismo* and *personalismo* can build trust and rapport in the development of a therapeutic relationship where Hispanic adults feel more comfortable in sharing. Moreover interventions and health promotion programs need to be developed from a community perspective that focuses on culture, language, affordability and ultimately effective.[18]

Although multiple studies have identified factors for the underutilization of mental health services, perhaps older Hispanic adults have a different explanatory model where mental health issues are not perceived as an illness but an inevitable part of everyday life.[26,35] The findings also suggest that development of interventions may be more effective if they expand upon the older Hispanic immigrants' cultural constructs which are embedded in their strategies used to cope with emotional distress and mental health issues. These include focusing on the extension of social support networks, learning constructive distracting activities, focusing on inner strengths and spirituality. For example, programs such as Jimenez et al.[40] Happy Older Latinos are Active (HOLA) which is a multicomponent health promotion intervention, focusing on social and physical activation sessions, group exercise and scheduling pleasant events show promise in reducing stress and depressive symptoms.

Limitations

This was an initial study exploring the way older, low income Hispanic immigrants cope with mental health issues and as such was not intended to be generalizable. Qualitative research methods are often

valuable in providing rich descriptions of complex phenomena, especially in relation to mental health issues. Although a considerable investment was made in order to develop a relationship with participants, the snowballing approach to recruitment seemed to help with establishing trust among the participants and interviewers in this study. In addition, the interviewers had to pay particular attention as to the source of the basis of the descriptions among the participants in depicting their responses to mental health issues. For example, some of the participants described their own ways of coping, while others described the ways that their family, friends or others coped with stress, anxiety and/or depression. Despite the frequent need to clarify, the interviewers were allowed to obtain a deeper understanding of participants' experiences and responses of coping with stress, anxiety and/or depression.

Conclusion

This study provides valuable insights into the ways of coping with mental health issues among older, low income, Hispanic immigrants and has implications for health care providers across all health care settings. The need to understand the responses to mental health among older Hispanic immigrants is crucial in developing strategies and interventions in health promotion and prevention of stress, anxiety and depression as well as treatment strategies. Incorporating the coping styles of the older Hispanic adult into the therapeutic plan by health care professionals may lead to more successful health and social outcomes. Inevitably, the relationship between the health care provider and older adult is important in the successful implementation of any program. Cultural constructs such as *familismo* (family) and *personalismo* (relationships) may be important areas to explore in developing the therapeutic relationship with older Hispanic adults in the primary care settings. Further research should focus on piloting programs aimed at prevention and coping with stress as well as recognizing sub clinical or depressive symptoms among older Hispanics across health care setting.

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References

1. Alegria M, Canino G, Rios R, et al. Inequalities in use of specialty mental health services among Latinos, African Americans, and non-Latino whites. *Psychiatr Serv*. 2002;53:1547–1555.
2. Alegria M, Chatterji P, Wells K, et al. Disparity in depression treatment among racial and ethnic minority populations in the United States. *Psychiatr Serv*. 2008;59(11):1264–1272.
3. Cabassa L, Zayas L, Hansen M. Latino adults' access to mental health care: a review of epidemiology studies. *Adm Policy Ment Health*. 2006;33(3):316–330.
4. National Hispanic Council on Aging (NHCOA). *Status of Hispanic Older Adults: Insights from the Field*. Washington, DC: NHCOA; 2016. Available at; http://www.nhcoa.org/wp-content/uploads/2016/09/2016-NHCOA-Status-of-Hispanic-Older-Adults-report-.pdf.
5. Zhan L. Improving mental health for ethnic older adults. *J Gerontol Nurs*. 2004;30(8):3.
6. Byers A, Lai A, Nelson C, et al. Predictors of mental health services use across the life course among racially-ethnically diverse adults. *Am J Geriatr Psychiatry*. 2007;25(11):1213–1222.
7. Institute of Health. *The Mental Health and Substance Use Workforce for Older Adults. In Whose Hands?* Washington, DC: Institute of Health; 2012.
8. Lando J, Williams SM, Sturgis S, Williams B. A logic model for the integration of mental health into chronic disease prevention and health promotion. *Prev Chronic Dis*. 2006;3(2):A61.
9. Bartels S, Naslund J. The underside of the silver tsunami – older adults and mental health care. *N Engl J Med*. 2013;368(6):493–494.
10. Flood M, Buckwalter K. Recommendations for mental health care of older adults. *J Gerontol Nurs*. 2009;35(2):26–33.
11. Shawler C. Assessing and maintaining mental health in elderly individuals. *Nurs Clin N Am*. 2010;45:635–650.
12. Alvarez P, Rengifo J, Emrani T, Gallagher-Thompson D. *Clin Gerontol*. 2014;37:33–48.
13. Harris KM, Edlund MJ, Larson S. Racial and ethnic differences in the mental health problems and use of mental health care. *Med Care*. 2005;43(8):775–784.
14. Cabassa L, Lester R, Zayas L. It's like being in a labyrinth:" Hispanic immigrants' perceptions of depression and attitudes toward treatments. *J Immigr Minor Health*. 2007;9(1):1–16.
15. Martinez Tyson D, Arriola N, Corvin J. Perceptions of depression and access to mental health care among Latino immigrants: looking beyond one size fits all. *Qual Health Res*. 2016;26(9):1289–1302.
16. Kuzel A. Sampling in qualitative inquiry. In: Crabtree W, Miller W, eds. *Doing Qualitative Research*. CA: Sage; 1999.
17. Polit D, Beck CT. *Nursing Research: Generating and Assessing Evidence for Nursing Practice*. 10th edition. New York: Wolters Kluwer; 2017.
18. Watson RS, Kaltman S, Townsend TG, Goode T, Campoli M. A collaborative mental health research agenda in a community of poor and underserved Latinos. *J Health Care Poor Underserved*. 2013;24:671–687.
19. Fontana A, Frey JH. The interview: from structured questions to negotiated text. In: Denzin NK, Lincoln YS, eds. *Handbook of Qualitative Research*. CA: Sage; 2000.
20. Domarad B, Buschmann MT. Interviewing older adults: increasing the credibility of interview data. *J Gerontol Nurs*. 1995;21(9):14–20.
21. Kvale S. *Interviews: An Introduction to Qualitative Research Interviewing*. CA: Sage; 1996.
22. Sandelowki M. Focus on research methods. Whatever happened to qualitative description? *Res Nurs Health*. 2000;23:334–340.
23. Crabree BF, Miller W. *Doing Qualitative Research*. CA: Sage; 1999.
24. Lincoln YS, Guba EG. *Naturalistic Inquiry*. CA: Sage; 1985.
25. Mental Health Commission of Canada. *Changing Directions, Changing Lives: The mental health strategy for Canada*. Calgary, AB: Mental Health Commission of Canada; 2012.
26. Whitley R, Wang J, Fleury M. Mental health status, health care utilization & service satisfaction among immigrants in Montreal: an epidemiological comparison. *Can J Psychiatry*. 2016;62(8):340–347.
27. Salude-Rios N, Tappen R, Williams CL, Rosselli M. Older Hispanics' explanatory model of depression. *Arch Psychiatr Nurs*. 2014;28:242–249.
28. Powell LH, Shahabi L, Thoresen C. Religion & spirituality: linkages to physical health. *Am Psychol*. 2003;58:36–52.
29. Lerman S, Jung M, Arredondo E. Religiosity prevalence and its association with depression and anxiety symptoms among Hispanic/Latino adults. *Plos One*. 2018;13(2):e0185661.
30. Harrison M, Koenig H, Hays J, et al. The epidemiology of religious coping: a review of recent literature. *Int Rev Psychiatry*. 2001;13:86–93.
31. Stanley M, Bush A, Camp M, et al. Older adults' preferences for religion/spirituality in treatment for anxiety and depression. *Aging Ment Health*. 2011;15(3):334–343.
32. Añez L, Paris M, Bedregal LE, Davidson L, Grilo CM. Application of cultural constructs in the care of first generation Latino clients in a community mental health setting. *J Psychiatr Pract*. 2005;11(4):221–230.
33. Savage B, Foli K, Edwards N, Abrahamson K. Familism and health care provision to Hispanic older adults. *J Gerontol Nurs*. 2016;42(1):21–29.
34. Beyene Y, Becker G, Mayen N. Perception of aging and sense of well-being among Latino elderly. *J Cross Cult Gerontol*. 2002;17(2):155–172.
35. Jimenez D, Bartels S, Cardenas V, Dhaliwal SS, Alegría M. Cultural beliefs and mental health treatment preferences of ethnically diverse older adult consumers in primary care. *Am J Geriatr Psychiatry*. 2012;20(6):533–542.
36. Martinez Pincay I, Guarnaccia P. It's like going through an Earthquake": anthropological perspectives on depression among Latino immigrants. *J Immigr Minor Health*. 2007;9:17–28.
37. Shattel M, Hamilton D, Starr SS, Jenkins CJ, Hinderliter NA. Mental health service needs of a Latino population: a community based participatory research project. *Issues Ment Health Nurs*. 2008;29:351–370.
38. Farley T, Galves A, Dickinson LM, De Jesus Diaz Perez M. Stress, coping and health: a comparison of Mexican Immigrants, Mexican-Americans and Non-Hispanic Whites. *J Immigr Health*. 2005;7(3):213–220.
39. Cooper L, Gonzales J, Gallo J, et al. The acceptability of treatment for depression among African-American, Hispanic and white primary care patients. *Med Care*. 2003;41(4):479–489.
40. Jimenez D, Syed S, Perdomo-Johnson D. HOLA, Amingos! Toward preventing anxiety and depression in older Latinos. *Am J of Geriatr Psychiatry*. 2018;26(2):250–256.