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Article

Toward a cultural adaptation of pharmacotherapy: Latino views of depression and antidepressant therapy

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Abstract

Relative to non-Latino Whites, Latinos in the United States with major depressive disorder (MDD) show low engagement in antidepressant therapy, whether engagement is defined as pharmacotherapy access, medication initiation, pill-taking, or treatment retention. One potential reason for this disparity in depression care is the low cultural congruence of pharmacotherapy for this population. To examine Latinos' views of depression and antidepressant therapy, we conducted qualitative interviews with 30

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Latino outpatients initiating antidepressants prior to their first treatment visit using the semistructured Treatment Adherence and Retention Questionnaire. These baseline interviews were randomly selected from data collected for a randomized controlled trial testing a novel intervention to enhance engagement by depressed Latino outpatients. Participant narratives were analyzed using open coding and the iterative analytical approach derived from grounded theory. Patient views about depression addressed stigmatizing views held by others in their social circle. Most participants directly refuted these views by providing alternate explanations to depression experiences. Antidepressant therapy narratives also revealed marked stigmatization, but participants tended not to refute these views. Instead, patients expressed concerns about antidepressants and showed marked ambivalence about seeking psychiatric care. Participants, however, did suggest ways in which clinicians and patients might collaborate to address their concerns about antidepressants. Some cultural views, such as concerns about addiction to or dependence on medication, may be negotiable barriers to treatment. Prescribing clinicians should address cultural views and concerns in order to improve Latino engagement in antidepressant therapy.

Keywords
antidepressant pharmacotherapy, cultural adaptation, engagement, Latino, stigma

Introduction

The value of adapting the delivery of psychotherapy to patients' social and cultural needs has been argued repeatedly in recent years (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; González Castro, Barrera, & Holleran Steiker, 2010). Increasingly, mental health practice attends to patients' perceptions of illness and treatment, since these can influence engagement and response to illness (Benish, Quintana, & Wampold, 2011; Petrie & Weinmann, 2006; Sirey et al., 2001; Smith, Domenech Rodríguez, & Bernal, 2011). Nevertheless, even as contextual factors become more salient in the delivery of psychotherapy, psychopharmacotherapy practice is becoming increasingly neurobiological (Mintz, 2005). Pharmacotherapists tend to emphasize "*what* to prescribe" and "may have neglected a focus on *how* to prescribe" (Mintz, 2005, p. 187). Yet, the impact of the perceptions and expectations of patients and their close associates regarding the use of medications for emotional distress is substantial (Cabassa & Zayas, 2007; Kleinman, 1988), especially on treatment engagement and adherence (Interian, Ang, Gara, Rodriguez, & Vega, 2011). Attending to cultural aspects of care is a crucial feature of interventions aiming to enhance patient engagement (Balán, Moyers, & Lewis-Fernández, 2013; Interian, Martínez, Iglesias Ríos, Krejci, & Guarnaccia, 2010; Kopelowicz et al., 2012).

Engagement problems in pharmacotherapy are prominent among U.S. Latinos[1] in need of mental health care (Lanouette, Folsom, Sciolla, & Jeste, 2009). Compared to non-Latino Whites, Latinos and other underserved racial/ethnic groups in the US exhibit worse engagement, whether defined as pharmacotherapy access, medication initiation, pill-taking, or treatment retention (Harman, Edlund, & Fortney, 2004; Lanouette et al., 2009; Olfson, Marcus, Tedeschi, & Wan, 2006; Sleath, Rubin, & Huston, 2003; Warden et al., 2007). For example, Latinos are only half as likely as Whites to initiate antidepressants (Harman et al., 2004) and are more likely to discontinue them within the first 30 days of treatment (Olfson et al., 2006). These effects persist after the effects of age, language, and insurance status are accounted for (Arnow et al., 2007; Harman et al., 2004; Miranda & Cooper, 2004; Olfson et al., 2006; Sánchez-Lacay et al., 2001; Warden et al., 2009; Warden et al., 2007).

What are the causes of this lower antidepressant engagement among Latinos, which persists even after addressing several structural barriers? The low cultural congruence of antidepressant therapy may be involved (Balán et al., 2013; Lewis-Fernández et al., 2013), since typical pharmacotherapy for depression may not meet common expectations among Latinos. Latino patients generally report: lower preference for antidepressants (Givens, Houston, van Voorhees, Ford, & Cooper, 2007; Miranda & Cooper, 2004), more concern that these medications are harmful and addictive (Cabassa, Lester, & Zayas, 2007; Givens et al., 2007; Interian, Martínez, et al., 2010), greater stigmatization of psycho-pharmacotherapy (Interian, Ang, et al., 2010; Lanouette et al., 2009; Martínez-Pincay & Guarnaccia, 2007), illness constructions inconsistent with antidepressant therapy (Cabassa et al., 2007; Lewis-Fernández, Das, Alfonso, Weissman, & Olfson, 2005; Schraufnagel, Wagner, Miranda, & Roy-Byrne, 2006), greater reliance on faith-based services to cope with depression (Cabassa et al., 2007; Givens et al., 2007), lower likelihood of communicating complaints to clinicians about antidepressants (Sleath, Rubin, & Wurst, 2003), and more unmet expectations about how clinicians should engage them in treatment (Cortés, Mulvaney-Day, Fortuna, Reinfeld, & Alegría, 2009; Interian, Martínez, et al., 2010; Martínez-Pincay & Guarnaccia, 2007; Schraufnagel et al., 2006). Such culturally salient concerns may be outside the scope of usual psychiatric practice. Several studies have explored views of depression and antidepressant therapy among Latinos, but have paid limited attention to how these views might be addressed by prescribers. Additionally, prior studies have not compared narratives across views of depression and antidepressant treatment, nor have they explored the perspectives of depressed Latinos prior to beginning antidepressant treatment. Matching treatment views between patient and clinician has resulted in enhanced treatment engagement in depression and other psychiatric disorders (Interian, Lewis-Fernández, Gara, & Escobar, 2013; Kopelowicz et al., 2012; Lewis-Fernández et al., 2013). Incorporating patient views is a critical component of shared decision making, which may enhance patient adherence to treatment, well-being, and satisfaction (Lin & Fagerlin, 2014). This has substantial public health implications, since elevated treatment discontinuation is associated with higher depression recurrence and disability and lower quality of life (Geddes et al., 2003; Lingam & Scott, 2002).

This article examines salient views of depression and pharmacotherapy among Latinos seeking outpatient antidepressant therapy and suggests possible strategies for engaging patients on these views prior to the onset of treatment. Our study aims were: (a) to identify the range of views regarding depression and antidepressant therapy among depressed Latinos, and (b) to explore how to address potential cultural barriers to pharmacotherapy engagement.

Method

Overview

Participants were Latino adults with major depressive disorder (MDD) who enrolled in a 9-month randomized controlled trial testing a novel approach using motivational interviewing for engaging and retaining outpatients in antidepressant therapy. Eligible participants who signed consent were randomized to one of two conditions: standard antidepressant therapy or the novel motivational interviewing-infused approach (Balán et al., 2013). Both conditions received psychopharmacological care only. Treatment retention was the primary study outcome. All participants completed several assessments during the study, including the semistructured Treatment Adherence and Retention Questionnaire (TARQ; see description below). Only baseline TARQ data were analyzed for this article; findings from the parent project will be published separately. The TARQ was conducted at baseline and at 12 and 36 weeks of treatment. Written informed consent was obtained from all participants; the Institutional Review Board of the New York State Psychiatric Institute approved the study.

Sample

A total of 217 individuals with MDD signed study consent, of whom 181 had a baseline TARQ interview and agreed for it to be recorded; the TARQ interview was conducted before beginning psychiatric treatment. To yield a manageable sample for qualitative analysis, we generated a table of 30 random participant identification numbers, which were utilized as a subsample for analysis. There were no significant differences in age, gender, income, or foreign birth between the 30 participants randomly selected for the present study and the original sample of 181 participants with audiotaped baseline TARQ interviews (results available upon request).

Interview

The TARQ was based on the Explanatory Model Interview Catalogue (EMIC) and developed by RLF and PJG (available upon request). The EMIC provides a paradigm for semistructured instruments assessing clinical ethnography topics including patterns of distress, perceived causes, preferences for treatment and other forms of help-seeking, and general views of illness (Weiss, 1997). TARQ questions were informed by the literature on known factors influencing help-seeking, treatment adherence, and treatment retention among Latinos, as well as by the clinical experience of the research team. The baseline TARQ included 41 open-ended and 46 closed-ended questions addressing participants' perspectives on various topics: participants' self-definitions of their experiences, acculturation, barriers to mental health treatment, views about antidepressants, expectations and history of treatment, side effect concerns, logistical barriers to engagement (e.g., transportation), family and friends' perspectives about depression, and stigma. Interviews were conducted by two female master's-level clinicians in Spanish or English, based on participant preference. Interviewers were trained by observing one of the TARQ developers (RLF) or an interviewer trained by RLF, then being observed during several interviews until judged proficient. TARQ interviews were usually conducted by the same interviewers who also screened participants for the larger study. Recordings were transcribed verbatim by an offsite transcription company.

Measures

Acculturation. The Bidimensional Acculturation Scale (BAS) for Latinos was used to measure acculturation (Marín & Gamba, 1996). The BAS consists of 24 items that assess language-related changes associated with acculturation experiences. Two subscales separately measure a "Hispanic" ($\alpha = .81$ in this sample) and "non-Hispanic" ($\alpha = .72$) orientation, scored separately, based on averaged scores on 4-point Likert scales measuring frequency ("Almost always to never") and proficiency ("Very well to very poorly"). Scores equal to or above the midpoint of 2.5 on one subscale alone indicate the person's orientation, while scores ≥ 2.5 on both subscales indicate a "bicultural" orientation. Average percent of life spent in the US was also assessed. This was calculated by dividing each participant's current age by the number of years the person has lived in the US (current age minus age arrived in the US) and calculating the mean percentage and the standard deviation for the sample (Alegría, 2009).

Clinical characteristics. Clinical assessments were conducted for the parent study. First, participants fulfilled criteria for MDD on the clinician-administered Structured Clinical Interview for DSM-IV (SCID-I; First, Spitzer, Gibbon, & Williams, 2002). Participants also had at least moderate severity at baseline (score ≥ 16) on the 17-item Hamilton Depression Scale (Hamilton, 1960). The interrater reliability of the Hamilton Depression Scale, 17-item version (HAMD-17) in the full sample of the parent study was .97. Individuals were excluded if they were actively suicidal, met criteria for alcohol or other substance abuse/dependence within 6 months of screening, had a history of bipolar disorder or psychosis, or were receiving effective treatment for depression. The Antidepressant Treatment History Form (Oquendo et al., 2003) was used to assess whether participants had previously sought antidepressant pharmacotherapy.

Data analysis

Qualitative data were analyzed using open coding and the iterative analytical approach derived from grounded theory (Strauss & Corbin, 1998); all interviews were coded in their original language. To develop the codebook, two authors first worked independently to review samples of interview transcripts noting a priori TARQ questions and emerging codes. Regular meetings were held with the rest of the research team to discuss interpretations, resolve disagreements, and refine and identify new codes. Through this iterative process a finalized codebook emerged. Using NVivo-8 (Richards, 2005), one coder applied the codebook to all 30 randomly selected interviews. During this process, the codebook was considered a living document and was revised throughout the data analysis. Descriptive memos were developed to create an audit trail describing relationships between categories and themes using the iterative method to capture the ideas about depression and antidepressant treatment of Latinos seeking mental health care. These were used to develop analytical memos with codes that consistently captured barriers to treatment. A scheme for organizing specific participant-held ideas or perceptions under general barrier topics was created, as supported by the data. The majority of participant data analyzed for this manuscript came from a subset of TARQ questions, listed in Table 1. Quotations from the transcripts were selected to best illustrate each topic and its interaction with underlying themes.[2] All translations from Spanish to English were by the first and last authors after the quotes had been selected for inclusion in the article.

Results

Sample characteristics

Participants were Spanish- or English-speaking Latinos ages 18 to 79 (see Table 2). Their mean baseline HAMD-17 score was 21.9, indicating moderate to severe depression. Mean duration of MDD was 11.9 years (range 0.3–55 years); 60% had previously received antidepressant treatment. Participants lived in New York City or the surrounding communities. Most were female and low-income, with 73.4% earning less than $19,999 annually per household; their mean age was 43.9 years (range 21–71) and they had on average 11.2 years of education. Most were unemployed or out of the labor force. Nearly all (96.7%) were foreign-born, from the Dominican Republic, Mexico, Ecuador, and other Latin American countries. Most participants had spent a majority of their lives outside of the US and displayed a “Hispanic” orientation on the acculturation scale. Only 20% were bicultural. Most (93%) preferred to be interviewed in Spanish.

Views about depression

Participants’ narratives focused on modifiable barriers to treatment, which referred to one of two topics addressed in separate interview questions: views about

Table 1. Sample TARQ questions.

- What brings you here to the clinic? [PROBE: What kind of problem?]
- In your opinion, what would help you deal with this problem? Why?
- What kind of difficulties do people have getting treatment for emotional or mental health problems?
- After a person starts mental health treatment, what could impede him or her from staying in that treatment?
- Thinking about the treatment that is about to start, what do you think the process will be like of coming to your appointments regularly? Why? [PROBE: What will make it difficult? What will make it easy?]
- Thinking about the treatment that is about to start, what do you think the process will be like of taking your medicine regularly? Why? [PROBE: What will make it difficult? What will make it easy?]
- Did you ever completely stop taking a medicine for a mental health problem without consulting the doctor? Tell me what happened. Why did you stop taking the medicine?
- How should one take medication for depression?
- In general, how long should your treatment with the medicine for depression last?
- How long do you think it will take for the medicine to make you feel better?
- What should you do if you are feeling well and you're still taking medication?
- When you think about receiving treatment with medication for your depression at this time, are there some side effects that you are concerned about? By "side effects" I mean symptoms or discomforts caused by the medicine itself.
- If you had side effects, what impact would this have on your continuing to take your medication?
-What can happen if someone takes medication for depression every day for a long time? Remember that there are no incorrect responses.
- There are people who believe that medicines for depression can be addictive. What do you think?
- There are people who believe that if you take medicines for depression there comes a point when you depend on them in order to function. What do you think?
- What does your family think about what is happening to you?
- In your opinion, what do people think or say when they hear that someone suffers from depression?

depression and views about antidepressant treatment. These topics encompassed an array of themes and respective thematic areas.

All participants understood and were able to easily discuss the concept of depression. At the start of the interview, most labeled their problem as depression. Those who did not initially use the label of depression focused instead on life problems or specific symptoms such as sleep disturbances and anhedonia. Many also reported anxiety in conjunction with depression. However, when asked about the cause of their depression or how antidepressants might help, most spoke about *nervios* (nerves), a Latino concept of distress (American Psychiatric Association, 2013; Guarnaccia, Lewis-Fernández, & Rivera Marano, 2003). For example, many participants said their depression could be treated by medication that "helps to regularize the nerves (*ayuda a regularizar los nervios*)."

Table 2. Sociodemographic characteristics of sample ($N = 30$).

	n	%	Mean	*SD*
Age			43.8	12.55
Education (years)			11.2	3.6
Gender (female)	19	63.3		
Country of birth[a]				
Argentina	2	6.7		
Dominican Republic	12	40.0		
Ecuador	4	13.3		
Mexico	6	20.0		
Other	6	20.0		
Income				
<9,999	11	36.7		
10,000 to 19,999	11	36.7		
20,000 to 39,999	5	16.7		
40,000 to 59,999	1	3.3		
80,000 to 99,000	1	3.3		
Did not to answer	1	3.3		
Employment status				
Employed (full-time/part-time)	13	43.3		
Unemployed	7	23.3		
Out of labor force[b]	10	33.3		
Acculturation				
BAS Hispanic orientation score			3.3	0.4
BAS non-Hispanic orientation score			2.1	0.8
Hispanic orientation	23	76.7		
Non-Hispanic orientation	1	3.3		
Bicultural orientation	6	20.0		
Age of arrival in the US, in years			24.7	11.3
Average percent of life spent in the US[c]			46.1	23.35
Clinical characteristics				
Baseline HAMD-17 score			21.9	3.7
Mean duration of MDD (years)			11.9	13.1
History of antidepressant treatment	18	60.0		

[a] Other: Cuba ($n = 1$), Honduras ($n = 1$), Peru ($n = 2$), Puerto Rico ($n = 1$), US ($n = 1$).
[b] Out of labor force: homemaker, student, receiving public assistance.
[c] $n = 25$.

Participants reported complex views about depression. They discussed several modifiable barriers encompassing two themes: *stigma* and *concerns about unrelenting depression*. Participants also described ways in which they coped with these barriers (see Table 3).

Stigmatizing attitudes toward depression. Participants described high levels of stigmatization regarding depression, which were held by others in their lives as well as by themselves. Participants consistently stated that others viewed depression as synonymous with madness (*loco/a, locura*). For example, Pablo explained that, as a result of his depression, people called him "that crazy one (*ese loco*)." Normative emotional expressions by those deemed "crazy," such as sadness or anguish, could also be ridiculed by others. Pablo described, "I look anguished and they would say, 'That one is already crazy (*ya está loco*).'" He chose not tell anyone about his current depression, "because what they do is ridicule me (*burlarse*)."

Participants often reported receiving negative labels because of their depression. Close associates, such as relatives, friends, or acquaintances, viewed participants' depression as a sign of personal weakness or lack of drive to feel better, as if, "you *want* to feel [depressed]... [and] that with just a little extra effort, you can get out of it." Attributions of personal weakness included failings in personal responsibility, self-indulgence, exaggeration, or feigning of illness. Other people viewed depression as something which "does not exist, something that you cause yourself," through excessive investment in your own dilemmas ("believing in your own crap"), dwelling on problems, attending too strongly to negative circumstances, or apathy about negative emotive states ("you let yourself fall and let it happen").

Lastly, some close associates perceived depression as an outcome of laziness. This at times was paired with the view that excessive negativity was a cause of depression, and with advice to actively overcome obstacles and to avoid undesirable emotional states as antidotes to depression ("*no darle mente*"; literally "give it no mind"). María explained that her family and friends said depressed people need to "put forth effort (*poner de su parte*), that it is not an illness... that depression is cured ... by oneself putting forth effort... and going to church." Many participants spoke of trying to follow these and other similar suggestions, but finding their depression unmanageable. Silvia described, "I have always been depressive... but with strong will (*fuerza de voluntad*) I have prevailed, but not now. The other [times I've used] the remedy of 'I won't pay attention,' of patching up the problem... and now... my mind says no." These views resulted in depressed persons feeling ostracized and misunderstood. Often, participants reported receiving negative feedback from their support networks. Diego described his father's attitude toward antidepressants as follows: "My father... doesn't agree with this... he says I can get better on my own, but it's not as easy as he thinks."

Concerns about unrelenting depression. Some participants thought that there are different types, or classes (*clases*), of depression. This suggested a range of severity and duration, such that many people expressed grave concerns about a type of

Table 3. Barrier themes and subthemes regarding views about depression

Barrier themes	Barrier subthemes	Sample quotes
Stigmatizing attitudes towards depression Disparaging views of depression, held by oneself or others	Depression is a sign of madness	"My husband says I am crazy because I suffer from depression." "Other people always tend to think that they [depressed people] are weak, that they cannot function well, like the rest of society" (weakness).
	Depression is a sign of negative personal characteristics	"People think you are making yourself out as the victim, or you are being silly . . . that it is just me wanting to feel bad" (self-indulgence). "[People] think it is like laziness . . . they say those people are apathetic, negative, that they do nothing to better themselves" (laziness).
	Others don't understand depression	"Since they are not living the situation they think the person is crazy . . . but they are giving an opinion from the outside."
Concerns about unrelenting depression View that depression exists on a gradient. Direness is indicated by the nature and duration of treatment.	Some types of depressions are chronic and incurable	"So far . . . they haven't told me what kind of depression I have." "[If a person takes medication for a prolonged period of time:] That doesn't have a cure."

depression that is severe, lifelong, and incurable. Each depression type was associated with differences in expected treatment: less severe, short-term depression could be treated with alternative remedies and did not require medication, whereas more severe, chronic depression might require medicinal intervention, which was felt to be "stronger" (*más fuerte*). Gabriela described her preference for natural medicine, like tea, but explained how it did not address her mental health needs: "I have always liked natural medicine, but you know . . . it is very delayed and . . . too mild (*suave*) for what I have," indicating her depression was too severe for alternate treatments. In general, participants often worried that taking psychiatric medication indexed a more severe form of depression, and delayed seeking psychiatric treatment out of fear that this indicated, to themselves and to others, that their depression was chronic or incurable. Indeed, participants often came to treatment because they had reached a state of extreme distress. Often, participants explained that only this severe type of depression warranted psychiatric intervention.

Participants were concerned with discovering where their experience fell on this gradient of depression severity and duration. Many people stated that this could be identified through clinical diagnosis, by administering tests or via the evaluation of a mental health professional. One participant expressed her frustration at not being located on this gradient: "so far . . . they haven't told me what class of depression I have." A few participants reported refusing psychiatric treatment in the past because they had not received a proper diagnosis that identified their type of depression. Even if they had received prior treatment, they often felt excluded from the diagnostic process. Pedro explained how this happened in his first experience seeking mental health: "[My psychiatrist] would give me tests similar to this one and I never knew what came of those tests." He eventually dropped out of that treatment.

Coping. Participants used the phrases *poner de mi parte* (do my fair share/put forth effort) and *fuerza de voluntad* (willpower) interchangeably, as means of coping with their depression. These emphasize the need for personal involvement, self-reliance, and responsibility in recovering from depression. As illustrated above, many participants thought one should attempt to get better from depression on one's own. Participants described the need to overcome (*sobrellevar*), fight (*luchar*), forget (*olvidar*), not pay attention to (*no darle mente*), or control themselves (*controlarme/controlarse*) regarding depression as a means of calling upon their internal willpower. These expressions represented variations of *poner de mi parte*, suggesting participants had a complex coping repertoire. Many participants described delaying psychiatric treatment by trying first to "keep fighting with my problems and control myself."

Although participants fought to deal with their depression and avoid treatment, they also described experiences of depression that differed from other-held stigmatizing views. While the latter emphasized notions of personal weakness and madness, participants' personal narratives directly responded to and refuted these widely held stigmatizing notions. When sociocultural norms dictated depression was an outcome of personal weakness, participants described depression as an experience marked by severe suffering. Popular associations of depression with social impairment, such as referring to depression as a "mental" problem, were challenged by personal stories of physical, "real" impairment. If others viewed depression as within personal control, participants suggested their depression was not within their control. Many participants explicitly phrased their responses based on what close associates said about depression, suggesting a sequential pattern to how they responded to others' views.

Views about antidepressant treatment

While most participants did not know how antidepressants worked, some said they did so by treating the nerves (*nervios*) somehow. A few others stated that antidepressants were used for chemical imbalances in the brain. Almost all participants were very hesitant to use antidepressants, expressing fear of their consequences. This was linked to four themes: stigmatizing views about antidepressants, notions about medication use that conflict with psychiatric recommendations, concern over adverse effects, and fear of dependence and addiction (see Table 4). As with views about depression, participants presented ways in which they were coping with these barriers.

Stigmatizing attitudes toward antidepressant treatment. Narratives revealed stigmatizing attitudes towards antidepressants. Participants reported hearing close associates state these views explicitly, resulting in scorn being directed at individuals who sought medication treatment for depression. Many participants expressed fear that these notions might be true, adding to their concern about taking antidepressants. Consequently, many participants resisted seeking psychiatric help, and experienced ambivalence about taking antidepressants.

Seeking psychiatric treatment was seen by participants and others as a sign of illness severity, and was associated with actual or potential madness. Participants reported fearing both that others would think they were mad if they took antidepressants and that taking medication meant that in fact they *were* mad or "not normal." Many participants explained how seeking psychiatric help was viewed as "not being all right in the head (*no estar bien de la cabeza*)." Instead, participants and close associates thought one should put forth effort (*poner de su parte*) to improve from depression. Options included, among others, reading helpful texts and religious practice. A few participants stated that for many in their community seeking professional help was "not an option," especially for people born abroad who had less access to medical care and experienced greater discrimination.

As a result, many participants had previously resisted taking medication to avoid stigmatization. They expressed fear that the medication could influence their behavior and mental state. The popular stigmatizing view was that people taking medication could become unpredictable or uncontrollable. Participants were concerned that medication reactions could involve unusual behavior, unstable

Table 4. Barrier themes and subthemes regarding views about antidepressant treatment

Barrier themes	Barrier subthemes	Sample quotes
Stigmatizing attitudes towards antidepressant treatment	Taking antidepressants or seeking psychiatric care is a sign of madness	"I didn't want . . . to get involved with the chemicals, the pills because . . . people were going to think 'she is crazy,' you know?"
Disparaging views of antidepressant treatment, either held by others or oneself	Antidepressants can impact people's behavior and mental state	"They see her more strangely because they don't know how she might react when she stops taking the medication" (People who go off antidepressants might behave unexpectedly).
		"They think that the medication is going to turn you cuckoo, if you are not cuckoo" (Medication for depression itself can make you mad).
	Medication is potent and can be dangerous	"[My friends say] they would never take this medication because it is a drug that is . . . dangerous."
Notions about medication use that conflict with psychiatric recommendations	Medications are a last resort	"If other things have not worked, then give medication a chance."
Folk ideas about antidepressants, including when and how to take medication	Depression should respond to medication immediately	"I think the first day [after taking medication for depression] there should be a change, even if small, but it has to do something."
	On days when feeling depressed, higher doses of medication should be taken	"[If] it's a little stronger [the dose], perhaps the effect will be quicker."
		"To be honest [I think] I should only take it when I feel depressed."

(continued)

Table 4. Continued

Barrier themes	Barrier subthemes	Sample quotes
	Antidepressants should only be taken when feeling depressed, not when feeling better	
Concerns over adverse effects of medications Concern about adverse reactions to medication (e.g., physical or emotional consequences that impair functioning)	Bodily consequences of taking medication	"I think it [the medication] will cause harm [*daño*] to my liver, stomach, all of that."
	Risk of worsening depression and deteriorating mental health	"The medicine [can] have an effect contrary to what I am expecting; instead of getting better I start to feel worse."
	High doses of medication are dangerous	"Someone told me . . . many people have died because they have been taking treatment for depression and . . . overdosed."
	Uncontrollable adverse effects	"If it were a very severe side effect, very strong, that . . . controls me and I don't control it."
	Alternative remedies have fewer adverse effects than antidepressants	"Natural medicines . . . did not have the same side effects I had with conventional medicines."
Fear of dependence and addiction Concerns that a person may become reliant on medication for life in order to carry out daily socioemotional functions; or that the person will develop a biologically rooted habit, involving	*Dependence*	
	Relying for life on medication for socioemotional functioning	"One becomes dependent on the medication to be well and able to do things."

(continued)

Table 4. Continued

Barrier themes	Barrier subthemes	Sample quotes
withdrawal, tolerance, and craving for medication		
	Going off the medication will make you depressed	“Afterwards one becomes depressed when not taking it [the antidepressant].”
	Dependence is a lack of willpower (*fuerza de voluntad)*	“That . . . is something personal because sometimes people don’t have a strong enough willpower (*fuerza de voluntad*).”
	Addiction	
	Addiction to antidepressants is related to biological mechanisms	“Perhaps afterwards your organism (*organismo*), your health will require it [medication], no?”
	Some medications are addictive and others are not	“I don’t know if this one [antidepressant] is addictive or not . . . I have heard there are many like that [addictive].”
	Addiction can be avoided by stopping the medication when you feel better	“It depends how you take them . . . If you for example use a medication for pain and that pain goes away . . . you won’t keep taking it with the same frequency.”
	Under the care of a doctor, you may be able to avoid addiction	“If they were addictive, the doctor would have to decide . . . I mean, if they were bad, the doctor would not give them to you.”
	Addiction can be avoided or surmounted if you have enough willpower (*fuerza de voluntad*)	“I am not a person who can become addicted . . . [because] I have willpower (*fuerza de voluntad*).”

mood, or inappropriate outbursts of emotion. Many participants also worried that antidepressants could exacerbate mood disturbances. Pamela explained why she avoided treatment in the past: "I thought . . . I am going to take medicine and my nerves are going to become unwell (*voy a estar mala de los nervios*), I will have to start seeing a psychiatrist—the psychiatrist is for crazy people." Daniela stated that her family thought antidepressants could also precipitate the onset of madness. Seeing a psychiatrist could be construed as a pathway to madness. Miguel explained how seeing a psychiatrist could yield further stigmatization: "[People say about a depressed person] that he is crazy . . . And if he sees a psychiatrist or something, they say, no, that one really becomes crazier every day. Because psychiatrists, they say . . . make people crazy."

Participants and their close associates viewed medications as potent and dangerous, leading those who took them to be approached with unease. Participants thought medications were "in some way strong" and should be used cautiously. As a result, taking an antidepressant had a large impact on people's social spheres. Many participants reported their support networks did not agree with their treatment decisions, resulting in tension or secrecy among family and friends. Often family members held stigmatizing views about antidepressant therapy. As a result, many participants experienced significant distress in seeking treatment. Ricardo explained this difficulty: "It took a lot from me to come [to the clinic] because of all the myths, the negative aspects . . . [attributed to] a person with depression . . . who sees a psychiatrist." People expressed embarrassment about the process, including routine psychiatric evaluations, or feeling uncomfortable with treatment.

Notions about medication use that conflict with psychiatric recommendations. Participants often revealed complex ideas about medication use. Overall, participants agreed medication was the strongest form of treatment and was a more aggressive intervention than psychotherapy. Many thought medication should only be taken when absolutely necessary and as a last resort. Prior to considering medication, many participants tried alternative treatments, such as drinking teas or trying to resolve problems on their own. Most sought help only when completely unable to cope: "If I were to find a solution . . . I would not look for help. But . . . this is overtaking me [*me está rebasando*]. And each time it's . . . more so."

Many participants held ideas that conflict with psychiatric information on antidepressants. For example, many participants thought that the medication should have at least some immediate effect. They also endorsed the notion that antidepressants should be stopped once the depressive symptoms started to improve. Some stated that if medication was not used in this way, it could indicate the depression was incurable. A few participants stated that higher doses of medication should be taken on days when feeling depressed, since this would help it work faster. Some also thought that medication should *only* be taken on those days, since the medicine treats one's mood, which fluctuates on a daily basis. Many participants formerly ceased treatment on their own without consulting their doctor once their depressive symptoms abated, thinking they could thereafter tackle problems on their own. Gabriela explained that she stopped going to a previous treatment because she at that point "thought I could . . . help myself without needing the medication."

Concerns over adverse effects of medications. Participants were often concerned about adverse effects which outweigh the benefits of antidepressants. Almost unequivocally, participants thought medication was harmful to the body. This concern was expressed nonspecifically, through the use of general terms like *daño* (harm), or through more precise concerns geared toward an organ (e.g., liver or stomach). A few people mentioned they were fearful of contracting "hepatitis" as a consequence of taking medication. Other concerns with bodily effects included fluctuations in weight, sleeping habits, sexual function, dizziness, and "the way they [medications] can alter my brain." Many participants were concerned about the consequences of taking a medication that interferes with one's neural chemistry. Emotional implications of physical adverse effects were also expressed. Elena described, "if . . . they need to remove my liver because I have hepatitis as a result of the medications, my depression will get worse, it will get stronger."

Participants also expressed fear of the medication worsening their depression, or de-stabilizing their mood without alleviating their depression. These worries often had led people to avoid treatment in the past. As a precaution, many avoided taking high doses of antidepressants. Participants desired to go on as low a dose as possible, and hoped to quickly go off medication to avoid extended exposure to potential harm. Some people were afraid of adverse effects so severe as to be uncontrollable, such as making them feel drugged or placing them at the mercy of others. Margarita said she worried over feeling "abobada" (befuddled) as a result of taking the medication, and that "other people could do with me whatever they want . . . that I would not be aware of what was happening."

Fear of dependence (depender/dependencia) *and addiction (*adicción). Overwhelmingly, participants thought antidepressants were addictive and could cause dependence. While some used the terms "addiction" and "dependence" interchangeably, or used terms that had both connotations such as "*crear hábito*" (become habit forming), most participants described addiction and dependence in distinct ways. Descriptions of becoming dependent on antidepressants typically focused on relying on medication in order to function and involved social and emotional impairments; addiction was usually explained through a biological framework, mirroring a narcotic model. In a few cases, the two phenomena were clearly distinct: some participants saw medication as causing dependence but not addiction.

Concerns over dependence were couched as "relying[3] on the medicine to function (*depender de la medicina para poder funcionar*)," that is, needing it to carry out daily activities and obligations. Many participants were frightened by the possibility of having to rely on the medication for life. Most explained that since medication helped relieve depression, improvements in *ánimo* (mood/wish to do things), and consequentially social functioning, were contingent on continued treatment. This in turn meant that if one took antidepressants, one would only be able to carry out social functions while on medication. Many reported hesitation to take antidepressants, driven by fear of such dependence.

Some participants endorsed fear of dependence because they had experienced a relapse of depression in the past after ending antidepressant therapy. Diana said she had formerly become reliant on antidepressants since, after going off her medication, "I did not feel the same. It's like... you go back, but worse." This had a day-by-day effect, so that "if you do not take [the medicine], you feel bad that day." Going off the medication, some participants said, would not only make one feel depressed again, but could also worsen one's depression. For some, these ramifications had previously led them to avoid antidepressants:

> [I]f I stop taking it... you can feel more down, more depressed, a greater sense of guilt or a desire to kill yourself... if I don't feel that way now, and by ceasing medication treatment I'd feel that way, well then I say things are just going to get worse.

Since coming off medication was seen as difficult, dependence could become lifelong. Some suggested this could be avoided by ceasing treatment as soon as one's depression started to lift. To continue recovering after this, some participants elaborated on the need to "*poner de su parte*" (put forth effort) to regain functioning on one's own, highlighting a difference between treating depressive symptoms and improving functioning. While medication might be needed to abate symptoms, restoration of functioning was more involved, and required the depressed person's effort. Ricardo explained:

> [Using medication for a long time] would be ... relying entirely on the pill to feel well. And the pills only, in my opinion, [should be used for] a limited time to help the person return to their normal state.

Thus, participants thought antidepressants should be used for symptom reduction, but that "effort is needed to function on your own." Frequently, dependence was interpreted as deficits in willpower and personal strength. For others, this was an irrelevant consideration, since they were not able to function at the time as a result of their depression; even if they became dependent, the medication would enable them to function.

Addiction was most often related to biological causes, such as changes in the brain or body. Some participants stated addiction was possible because the medication "has to do with the brain," and its "chemicals," triggering reactions which mirrored other illegal substances, such that "afterwards one becomes 'hooked' (*uno se juquea*) ... and ... cannot be without those medications." Explanations of addiction were often based on a drug model, so that one's experience as a medication user could become similar to a *drogadicción* (drug addiction), involving notions of withdrawal, tolerance, and cravings for the antidepressant. Elena described seeing her friend experience withdrawal from an antidepressant: “she would go crazy without her medication and she would cry on the phone asking her mother for help.” The role of the brain in explaining addiction often led to the conclusion that antidepressants worked at the level of the body. Participants were concerned over the perceived potency of medication, which would create “fear of decreasing the dosage to go off medication” because, they believed, “the body needs it.” This focus on the body helped explain the addictive potential of antidepressants, since other addictions (e.g., to drugs) were biologically based and could be identified by bodily symptoms (e.g., withdrawal).

To many, addiction was inevitable, while others stated that nonaddictive treatment options existed. Some expressed a desire to be prescribed nonaddictive antidepressants, or suggested that while addictive medications existed, that was not the medication they were on. For example, Ernesto stated, “There must be some that are addictive, but the one I will take is not.” To avoid addiction, participants recommended practices similar to those mentioned above for avoiding dependence on medication. A few provided a rationale based on analgesics, in which one only took medications when in pain. Many warned that doing otherwise would constitute medication abuse (*abuso/abusar*), possibly resulting in addiction.

While most participants acknowledged the common view that medication for depression is addictive, many held alternative personal opinions. Sometimes this was based on previous experiences in which participants did not develop an addiction to medications, or on medical information which they acquired. Although doubts frequently remained, participants would defer to their doctors, stating their intent to follow their clinician’s instructions. For instance, Carolina said, “I have heard that if you take it every day, they are addictive every day. But I think that... if the doctor says you must take it, you must take it. He will know when to stop it.” Despite these stated intentions, many revealed past instances of nonadherence during their own previous treatment with psychiatric medications.

Faced with the looming threat of addiction, some participants suggested that they were responsible for allowing themselves to be vulnerable to addiction, and that *fuerza de voluntad* (willpower) was required to overcome addiction. However, the process of becoming addicted, and addiction itself, were usually attributed to external factors, such as the potency of medication or lack of supervision by a doctor.

Coping. As an alternative to seeking highly stigmatized treatment, participants said one could *poner de su parte* to improve from depression by first seeking alternative remedies, such as drinking teas or doing exercise. Some participants stated that they had previously tried using these remedies, but without the desired effect. Others explained that while they preferred natural options such as exercise, their depression was so severe that they were unable to engage in these activities. Carmen explained, “If I go to the gym, I feel better as well, but right now I feel so impotent, so bad, that I can’t find the way to go exercise.” Most were distressed by seeking psychiatric care, arriving to treatment only after trying to overcome their depression, but finding that “the fight (*lucha*) was so strong that I afterward fell.” Unlike their response to stigmatizing views about depression, participants rarely provided personal refutations to stigmatizing views about medication. They often expressed doubt or uncertainty about participating in treatment. As a result of these concerns, participants presented various coping strategies for minimizing exposure to the risks of taking antidepressants.

Without directly contradicting what others said about antidepressants, a few participants offered alternative paradigms under which a person might seek psychiatric care and avoid stigmatizing labels. Elena explained that while others thought visiting a psychiatrist was “a thing crazy people do (*cosa de loco*),” she thought treatment was meant “to help everyone, crazy people and those who are not crazy.” Others suggested alternate views about personal responsibility and *poner de mi parte*. For example, a few participants spoke of ways in which *poner de mi parte* meant engaging with mental health treatment; doing your fair share could mean attending your appointments and taking your antidepressants on schedule, thereby collaborating with your doctor. Others mentioned the need to put forth effort to “take on the wish to get better (*emprender el deseo de curarme*),” or by working “with” antidepressants in tackling interpersonal issues, “because in spite of being in treatment, things will come up that trigger memories, or problems [will arise] that you have to confront.” The idea of working together with one’s doctor also came across at different points in the interview, when participants with former treatment experiences complained of former doctors who “don’t guide you well throughout the process of the medication. You don’t know what to expect from the medication.” Others discussed feeling their past prescribers did not consider patients’ concerns about antidepressants. Norma stated she felt her “doctor . . . was not so much for me—it’s like he limited himself to just doing, to only prescribing.”

Discussion

Few Latinos access psychiatric care and fewer stay and adhere to antidepressant therapy as prescribed (Lanouette et al., 2009; Vega, Bohdan, Aguilar-Gaxiola, & Catalano, 1999). Our findings show that low-income, first-generation Latino psychiatric outpatients attribute a range of meanings and concerns to depression and to antidepressant therapy. These participants reported high levels of stigmatization conveyed by close associates regarding both the illness and its medication treatment. Although some participants endorsed these stigmatizing views of depression, many more refuted them. By contrast, participants rarely refuted stigmatizing views about antidepressant therapy. Instead, they frequently presented other-held views and said little about how they personally responded to the stigma. They also shared multiple concerns about medication treatment. These included fears of adverse effects and of becoming dependent on or addicted to antidepressants. Although the patients were about to embark on a 9-month antidepressant trial, they expressed marked ambivalence about the modality of treatment they had agreed to. They expected to use antidepressants sparingly, in parallel with the presence of depressive symptoms; most suggested they would cease treatment as soon as their symptoms abated. Many thought that antidepressants would not restore social functioning, but rather that recovery would be attained only through *poner de mi parte* (putting forth effort). Interestingly, some participants suggested that concerns about dependence and addiction could be negotiated with prescribing clinicians, such that addressing these risks might help participants feel protected. Their views suggest possible ways in which *poner de su parte* could be used to help engage patients in the prescribed treatment.

Before proceeding, a few study limitations should be noted. Our findings reflect the views of Latinos who sought pharmacotherapy for MDD. Views of depressed Latinos not interested in antidepressants might differ from those of this sample. Second, our participants were recruited via ads that focused on depression. This likely resulted in a sample familiar with the concept. Furthermore, following a thorough screening process, participants may have learned to label their mood as depressed. The TARQ asked fewer questions about depression than about antidepressant therapy. It is possible that additional questions about depression might reveal more complex ideas. The interview also directly asked participants about addiction and dependence concerns. Although some participants introduced these topics on their own, others may not have discussed these concerns as saliently. Our sample was almost entirely low-income and first-generation primarily from the Dominican Republic and Mexico; a different Latino composition might result in different findings. Lastly, our cross-sectional analysis did not allow us to examine how patient views changed over the course of treatment. In future work, we plan to examine these important questions with data from the TARQs conducted at Weeks 12 and 36.

Previous studies have described stigmatizing sociocultural norms about depression and antidepressant therapy among Latinos, including that the use of medication indicates weakness, lack of resiliency, or severe problems such as being crazy (*loco*; Cabassa, Hansen, Palinkas, & Ell, 2008; Cabassa et al., 2007; Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007; Interian, Martinez, et al., 2010; Martínez-Pincay & Guarnaccia, 2007). Latino views echo widespread notions that emphasize the role of personal control in depression, suggesting that the patient is to blame for its onset and continuation (Brockington, Hall, Levings, & Murphy, 1993; Corrigan et al., 2000; Hamre, Dahl, & Malt, 1994; Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999). Exposure to these and other stigmatizing views influences whether Latinos engage in mental health care (Interian et al., 2007; Vega, Rodriguez, & Ang, 2010). Most participants in our study described exposure to marked public stigma (Corrigan & Watson, 2002) about depression and antidepressant treatment from close associates. Many, but not all, Latinos in our study refuted these stigmatizing views when it came to their own experience of depressive illness. They provided alternative depression narratives, rejecting the internalization of self-stigma (Corrigan, 2004). However, many did not tell others in their social circle about their depression and few participants challenged other-held stigmatizing views of depression more generally, suggesting public stigma was harder to refute. Latinos often keep their depression a secret to avoid bringing shame to themselves and their families (Cabassa et al., 2008) and possibly to bolster their ongoing engagement in care through secrecy, as relatives' perceptions appear to play a big role in Latinos' help-seeking behaviors (Martínez, Interian, & Guarnaccia, 2013). This emphasizes the need to understand both other-held and personal views about depression and stigma among Latinos as they participate in psychiatric care.

Prior research has found that Latinos often view depression as a severe illness, in which severity and duration of illness are related (Cabassa, 2007; Martínez-Pincay & Guarnaccia, 2007). Our participants suggested a continuum of depressive experiences, ranging from manageable and short-term to severe and lifelong. This parallels the broad range of the cultural concept of *nervios* (nerves) in this population. *Nervios* as an idiom of distress ranges from a mild, nonstigmatized—almost expectable—reaction to the accumulation of life stresses with limited functional impairment (e.g., baseline mild anxiety or depressive symptoms that flare after new moderate stressors) to severely impairing and highly stigmatized psychopathology, such as psychotic episodes or marked, refractory depression (American Psychiatric Association, 2013). It is possible that our sample's description of the "classes" of depression reflects this preexisting, folk understanding of the range of reactions to adversity. The underlying etiological assumptions regarding this range of severity need to be clarified. Cabassa et al. (2007) found that most Latinos in their sample attributed their depression to sociological circumstances rather than biological dysfunctions. Our findings also yield a division between bodily and social explanations. However, while many participants attributed the cause of their depression to life factors, they also stressed their physical symptoms and consequent impairment. When asked directly about the way in which antidepressants work, a few participants attributed their depression to a chemical imbalance. This suggests that depressed low-income Latinos likely hold a mix of etiological views about depression, combining sociosomatic and biomedical concepts, which are refracted through the lens of their own illness experience.

In terms of depression pharmacotherapy, our patients were more loath to directly challenge other-held, stigmatizing views of antidepressants, at least during their baseline interview prior to initiating this form of treatment. Patients described strongly ambivalent feelings about medication and searched for nuanced ways of negotiating their commitment to pharmacotherapy, while acknowledging their concerns. For example, some suggested that different types of antidepressants existed, which varied in strength, duration of use, and potential for dependence and addiction. The breakdown of depression into milder and severe "classes" facilitated this possibility. Diagnosis thus attained a special salience, especially in terms of guiding treatment. Several participants called for a more sophisticated explanation of their diagnosis than the simple label of "major depression" they had received, as the "class" of their depression was associated in their mind with prognosis and treatment trajectory. This need for diagnosis seems contrary to research suggesting

Latinos resist diagnosis in order to avoiding labeling, due to fear of stereotyping (Interian et al., 2007). In our sample, the hope for a milder form of depression appeared to be a coping response aimed at resolving the ambivalence over initiating antidepressant therapy. Perhaps if a person's depression were not too severe, the antidepressant used would be milder, short-lived, and less likely to cause dependence and addiction. Participants struggled to combine their own experience of the illness and the need for effective treatment with community norms about these topics, especially when confronted with frightening views about psychiatric medication. These ideas may also allow them to escape the worst aspects of the depression label, reducing their own self-stigma, and providing some rationale for their treatment choice. Our findings generally confirm previous work on the association of medication use with the fear of lifelong depression (Martínez-Pincay & Guarnaccia, 2007) and also suggest how to help patients resolve their ambivalence toward medication and reduce self-stigma about the illness label. This is a fruitful area of research, as clinicians strive to help Latino patients "neutralize reactivity to stigma" (Vega et al., 2010, p. 188), given the key role stigmatization plays in antidepressant disengagement (Interian et al., 2011; Vega et al., 2010). By understanding how depressed Latinos cope with stigma, clinicians can improve patient-centered communication in order to discuss and process patients' ideas about depression and treatment (Balán et al., 2013; Interian et al., 2011).

Notions of control, both external and internal, appeared recurrently throughout patient narratives (Lewis-Fernández, 1998; Lewis-Fernández & Aggarwal, in press). Participants wanted to be personally involved and responsible for their depression and treatment, across multiple stages of their experiences. Some participants explicitly wished their former prescribers had engaged them more closely, discussing patient concerns and treatment plans. Many reported dropping out of past treatments with which they were dissatisfied. Our findings present options to clinicians for discussing and negotiating culturally interpreted modifiable barriers to treatment, following an approach consistent with recent work on shared decision-making (Lin & Fagerlin, 2014). Patients might be engaged in treatment through reframing the concept of *poner de mi parte*. Interian, Martinez, et al. (2010) identified this as an important value to Latinos seeking antidepressant care, which "reflects an internal sense of responsibility for action" and has "the potential to serve as motivators or complications to adherence" (p. 220). Understanding the intricacies of cultural values such as *poner de mi parte* highlights the importance of aligning clinician and patient goals (Interian, Martinez, et al., 2010). This could be done in several ways. For instance, clinicians could use *poner de mi parte* to foster patients' personal involvement in treatment. Patients might be able to "put forth effort" by taking their antidepressants, or discussing with their doctor risks for addiction or dependence. Patients might also *poner de su parte* in treatment by being attuned to their experience using medication, in order to provide feedback to their clinicians. Caution should be exercised, however, in using this idiom; clinicians may run the risk of appearing confrontational when referencing *poner de su parte*. One way this can be avoided is to mirror patient language about past coping behaviors or barriers, or to present the phrase as a way to gauge from patients what they have done in the past to *poner de su parte*.

Our findings on the nuanced differences between dependence and addiction can also help guide care. Part of patients' ambivalence about taking antidepressants for more than a few days or weeks relates to their concern about dependence: in effect, that they would come to rely on the medication to carry out daily tasks. Like a crutch, or a cast, medication may be necessary for a while, but if used too long may lead to permanent atrophy of the treated limb. Patients' response is to monitor their improvement closely, and taper down or discontinue the medication at the right moment after improvement is detected. The hope is to initiate a sustained recovery without overusing the curative agent. According to this view, since full recovery requires *poner de su parte* in any case, and antidepressants by themselves are often not fully effective, it is always a matter of *when* not *whether* to discontinue the medication so that the person can complete the healing on his/her own. These findings expand on prior work noting the importance of restoring functioning, especially as it relates to daily familial responsibilities such as childrearing, to the decision among low-income Latinos to seek psychiatric help (Martínez et al., 2013). Prior work also noted the limited role that medications play in this overall quest, mainly in helping to regain control (Martínez-Pincay & Guarnaccia, 2007). Although concern with psychosocial impairment might get Latino patients to treatment, initial restoration of functioning might paradoxically *lower* retention in antidepressant therapy. Concepts of *dependence* thus index issues of internal regulation and personal control. In comparison, *addiction* was described in terms of bodily cravings for medication, largely caused by external factors, such as the compound's inherent chemical properties. Though some degree of lapse of willpower may be involved, addiction was at least partly out of personal control. These views can help tailor patient educational activities to address concerns about addiction and dependence. Clinicians could explore these perspectives with Latino patients in order to examine how they impact engagement.

In conclusion, our study emphasizes the importance of understanding and addressing cultural views of depression and treatment in antidepressant therapy. Much as in psychotherapy, pharmacotherapy needs to undergo its own version of cultural adaptation. The fact that the medication comes as a standard preparation does not exempt clinicians from attending to culture-related concerns and expectations about treatment. Latino patients tend to experience marked ambivalence about seeking psychiatric care and attribute complex meanings to antidepressants. Integrating cultural views into psycho-pharmacotherapy can help patients negotiate and address their views in order to improve treatment engagement. Research has been growing in this area with Latino populations (Balán et al., 2013; Interian, Martinez, et al., 2010; Kopelowicz et al., 2012; Lewis-Fernández et al., 2013). To date, findings confirm the positive impact on engagement of culturally adapted pharmacotherapies.

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Trial registration

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Notes

1. "Latinos" refers to persons in the United States who are of Latin American descent, including Mexico, the Spanish-speaking Caribbean, Central America, and South America. Some authors also include Spaniards under this designation.
2. Participants are identified by pseudonyms to protect anonymity.
3. While in Spanish participants used the term *depender*, the conveyed meaning is closer to the English notion of reliance.

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