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Disclosing Psychiatric Diagnosis to Close Others: A Cultural Framework based on Older Latin@s Participating in a Depression Trial in Los Angeles County

Dahlia Fuentes, PHD, MSW, MPH,
USC Edward R. Roybal Institute on Aging, USC Suzanne Dworak-Peck School of Social Work, University of Southern California, 1150 S. Olive Street (Suite 1400), Los Angeles, CA 90015, Telephone: (619) 248-4737;

María P. Aranda, PHD, LCSW, MPA
USC Edward R. Roybal Institute on Aging, USC Suzanne Dworak-Peck School of Social Work, University of Southern California, 1150 S. Olive Street (Suite 1400), Los Angeles, CA 90015, Telephone: (213) 740-0286;

María P. Aranda: aranda@usc.edu

Abstract

Objectives: The objective of this qualitative study is to explore disclosure of depression diagnosis to close others among older adult Latinas/Latinos (Latin@s) recruited from an urban health care system specializing in low-cost community health services in Los Angeles County.

Methods: Semi-structured in-depth interviews were conducted with 35 older Latinos who participated in an NIMH-funded randomized depression trial.

Results: Psychiatric disclosure is a dynamic, multidimensional, and culturally ladened experience that entails weighing in on interrelated factors. This study presents a cultural framework of depression disclosure that highlights 15 facilitators and barriers which were organized into three intrinsic and relational domains: (a) individual emotional and support needs; (b) personal characteristics of the recipient of the disclosure; and (c) quality of the interpersonal interactions between the patient and recipient.

Conclusion: Knowledge of Latin@ older adults' perspectives and experiences with depression disclosure can inform strategies to support older Latin@s facing the dilemma of disclosure.

Keywords

depression; disclosure; Latino; older adults; cultural framework

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Please address all correspondence to: Dahlia Fuentes, PHD, MSW, MPH, USC Edward R. Roybal Institute on Aging, USC Suzanne Dworak-Peck School of Social Work, 1150 S. Olive Street (Suite 1400), Los Angeles, CA 90015. Telephone: (619) 248-4737. Dahlia.Fuentes@gmail.com.

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Introduction

Self-disclosure is defined as the process of communication that makes the self known to others, often by verbally revealing personal information (Cozby, 1973). Self-disclosure (herein disclosure) can encompass various topics and prompt personal benefits. However, when the content of disclosure is a stigmatized identity (mental illness, HIV status), persons may negotiate certain factors that influence the decision. In this article, older Spanish-speaking Latina/Latinos (herein Latin@ or Latin@s) in the USA reveal the reasons why they disclose their depression diagnosis. Depression is a common and debilitating illness associated with losses in health-related quality of life (Pyne et al., 1997; Unützer et al., 2000) and is a leading cause of disease (Chapman and Perry, 2008; Moussavi et al., 2007). Although rates of geriatric depression are among the highest for immigrant Latin@s aged 60 or older in the USA (Jimenez, Alegría, Chen, Chan, & Laderman, 2010), minimal depression research has been conducted with this culturally-distinct population (Fuentes and Aranda, 2012).

Stigma and other factors that influence mental illness disclosure

Mental illness has long been the matter of stigmatization (Angermeyer and Matschinger, 1994; Corrigan and Penn, 1999; Goffman, 1963), despite recent advances in public knowledge of biological correlates of mental illness and increased acceptance of treatment (Schomerus et al., 2012). Mental illness stigma has been positively correlated with secrecy coping in diverse samples from the USA (Chen, Lai, & Yang, 2013; Chronister, Chou, & Liao, 2013), the United Kingdom (Kleim et al., 2008; O'Mahen, Henshaw, Jones, & Flynn, 2011), and Singapore (Yow and Mehta, 2010), indicating that stigma is a disclosure barrier worldwide. Disclosure is less likely if the individual considers depression to be a permanent, disabling, and stigmatizing condition (Weich, Morgan, King, & Nazareth, 2007). Greater comfort with disclosing is associated with lower anticipated discrimination and lower stigma stress (Rusch, Brohan, Gabbidon, Thornicroft, & Clement, 2014).

A growing body of literature exists on stigma and negative attitudes toward mental illness among racial and ethnic minorities and older adults (Anglin, Link, & Phelan, 2006; Corrigan and Watson, 2007; Jimenez, Bartels, Cardenas, & Alegría, 2013; Rao, Feinglass, & Corrigan, 2007; Whaley, 1997) and the negative impact on revealing mental illness in help-seeking and mental health services use (Conner, Koeske, & Brown, 2009; Eisenberg, Downs, Golberstein, & Zivin, 2009; Gary, 2005; Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007; Jang, Chiriboga, Herrera, Tyson, & Schonfeld, 2011; Sirey, 2001; Snowden, 2001; Ting and Hwang, 2009). Yet, none address the disclosure experience on older Latin@s in the USA. Thus, we explored the facilitators and barriers to disclosure of depression diagnosis to close others by primarily Spanish-speaking older adult consumers of health care services.

Although stigma plays an important role in disclosure, stigmatized individuals are not necessarily passive victims of others' negative stereotypes (Major and O'Brien, 2005). Persons' own cognitions play a mediating role in disclosure decisions (Corrigan and Watson, 2002a, 2002b; Link, Struening, Neese-Todd, Asmussen, & Phelan, 2001). Strategies to manage self-stigma include hiding the illness (social avoidance, secrecy, selective disclosure) or affirming the person with mental illness (indiscriminate disclosure, broadcasting); (Corrigan and Matthews, 2003; Corrigan and Rao, 2012; Link, Mirotznik, & Cullen, 1991; Rüsch, Angermeyer, & Corrigan, 2005; Rüsch et al., 2009). Thus, disclosure may be a strategy for not only managing stigma but also improving quality of life (Corrigan et al., 2010). Other factors may facilitate disclosure such as the expectation of favorable outcomes, increased self-esteem, emotional catharsis, social support, relationship closeness, and access to care (Chen, et al., 2013; Derlega, Winstead, Greene, Serovich, & Elwood, 2004; Valle and Levy, 2009; Wohl et al., 2011; Zea, Reisen, Poppen, & Echeverry, 2005). Yet the literature on disclosure is focused predominantly on stigma such that it minimizes other factors such as culturally-defined beliefs about whom to disclose, and why.

Mental illness disclosure and culture

Assumptions that the experience of disclosure is the same across all segments of society remain unwarranted. Cultural explanatory models explain illness etiology, symptom onset, pathophysiology, course of sickness, and treatment (see Camacho, Estrada, Lagomasino, Aranda, & Green, 2017: Kleinman, Eisenberg, & Good, 1978). Through explanatory models, cultures define appropriate responses to illnesses, including disclosure behavior. Although there is scant research on the experience of disclosure among Latin@s and other racial and ethnic minorities, we posit that cultural values and beliefs related to persons who self-identify as Latin@, play a role in the disclosure experience.

As a foundational value of Latin@ cultures, allocentrism (collectivism) reflects the needs, objectives, and points of view of the in-group and emphasizes close, nurturing, and supportive interpersonal relationships through high levels of personal interdependence (La Roche, D’angelo, Gualdron, & Leavell, 2006; Marin and Triandis, 1985). In contrast, individualist cultures determine social behavior primarily based on personal objectives, attitudes, and values often unrelated to and independent of the in-group: Latin@ values of *simpatía* (kindness, interpersonal harmony), *familismo* (familism), and *respeto* (respect) derive from collectivism and are associated with mental health treatment adherence (Marín and Marín, 1991). These values and beliefs influence mental health disclosure to the extent that the person makes a conscious effort to hide or reveal their diagnosis. Thus, we offer a cultural framework of mental illness disclosure based on the experiences and cultural schemas of older Latin@s participating in a randomized depression trial in Los Angeles County, USA.

Methods

Methodological orientation

Since the study focused on an exploration of experience and perceptions, the qualitative and interpretive methodology of phenomenology was used. Data was collected via individual face-to-face semi-structured interviews, a commonly used method in the phenomenological approach as it allows deep exploration of participants’ experiences; further probing by the interviewer provided opportunities for clarification and exploration (Padgett, 2016).

Participant selection

The phenomenological inquiry of disclosure took place in the context of a pilot randomized behavioral trial for older Latin@s with comorbid major depression and medical illnesses. The pilot, Programa Mano Amiga (PMA), explored the feasibility and acceptability of adding individually administered Problem Solving Therapy (PST) to enhanced usual care to treat depression in an urban healthcare system specializing in low-cost community health services in Los Angeles County. The study was open to Latin@s aged 60 or over diagnosed with major depression by trained bilingual study personnel.

A total of 100 primarily Spanish-speaking participants were enrolled in the larger study. Two thirds of participants were randomized into the PST intervention (a brief, manualized psychosocial treatment provided by research interventionists (Arean, Hegel, Vannoy, Fan, & Unuzter, 2008); while one-third was allocated to the enhanced usual care (psychoeducational materials, referrals to specialty mental health providers). The difference in treatment allocation rates was a function of the pilot nature of the parent study which examined the feasibility and acceptability of the intervention. After treatment, 85 of the 100 participants completed a 4-month outcome assessment. Participants were randomly selected until a predetermined number (35) of qualitative interviews were conducted. This allowed us to reach saturation in the various phenomena explored (depression disclosure, complexities of depression management, and PST). Participant characteristics are summarized in Table 1. The average depression severity score on the Hamilton Depression Rating Scale was 23.77 ($SD = 4.57$), indicating severe depression.

Setting, data collection, and analysis

Interviews were conducted at the healthcare sites, or participants' homes, averaged 90 minutes, and followed a semi-structured interview guide containing open-ended questions with probes to share anything that may have influenced disclosure decisions regardless of how remote they appeared. To equalize the hierarchical power position of participant and interviewer, conversational by-play, light humor, and opportunities to engage in tangents were given ample time. All interviews were audio recorded and transcribed in the language conducted. Field notes and summaries were completed during and immediately after each interview. We engaged in an iterative process of data collection and analysis, where new information from interviews informed the questioning route and probes of proceeding interviews. Transcripts were not returned to participants for comment and repeat interviews were not carried out due to limited time and resources. The study protocol was approved by the affiliated institutional review board.

QSR NVivo was used for qualitative data management and analysis (Fraser, 2000). Data was analyzed using a thematic approach where three PMA team members read the transcripts several times while listening to the interviews to fully understand their content; then independently extracted phrases and sentences that pertained to participants' lived experience of depression disclosure (Colaizzi, 1978). Constant comparison was used to determine whether a particular topic was similar or different to a topic raised earlier and when discussion of a particular topic began and ended (Willms et al., 1990). Codes were assigned to transcript segments reflecting meanings formulated from the significant statements and phrases. After each team member independently coded a selection of transcripts, codes were discussed, matched, and integrated into one codebook through consensus. Disagreements in assignment or description of codes were resolved through discussion among team members and review of audiotapes. The codes of formulated meanings were clustered into themes on depression disclosure reported herewith.

Results

We found 31 of the 35 participants disclosed their depression diagnosis to at least one person. Deciding whether to disclose entailed weighing intrinsic and relational domains, including: (a) the patient's individual emotional and support needs (cathartic experience, shame); (b) the personal characteristics of the recipients (attentiveness, rejection); and (c) the quality of the interpersonal interactions between the patient and recipient (trust, cause no suffering). Participants did not disclose indiscriminately; they were selective and considered factors that either facilitated or impeded disclosure. Thematic schemas based on participants' accounts of disclosure facilitators and barriers are organized according to this framework of individual needs, recipient characteristics, and quality of the relationship (see Table 2). Although we use the term barriers, this does not necessarily imply that depression disclosure did not occur.

Facilitators of depression diagnosis disclosure

Individual needs

Cathartic experience (es un desahogo).: The need to vent emotions (cathartic experience) was a prominent facilitator of disclosure identified by most participants. In Spanish, *desahogo* is a figurative "undrowning" or venting. One participant exclaimed, "I couldn't take it! Could not take it! I came out. I had to talk with somebody!" Another participant explained, "One needs to tell another person to release it. If you talk about it, you vent. Then you feel at ease."

Needing help (necesito ayuda).: The perceived need for tangible help tended to facilitate disclosure. For instance, some participants expressed disclosing because "I needed them" and "to get their advice." Coupled with trust (*confianza*), the need for help also facilitated disclosure. "Trust or wondering if they could help me with something."

Depression awareness and severity (antes no sabía).: Both the lack of depression awareness and perceived lower depression severity delayed disclosure for some participants. One participant had not disclosed prior to participation in the study "because before, I didn't know what depression was." Another participant postulated that others may not disclose "because like in my first stage, they're not even aware that they have depression." Yet, once they discovered they had depression, and saw that it was severe, they disclosed to others. One participant expressed the difference in her disclosure behavior between two periods in her life characterized by depression severity: "I had depression, but didn't want to tell anybody because I took it like something that would pass. Now the depression is very strong; everybody knows about it."

Recipient's characteristics

Won't divulge (no lo anda contando).: Knowing that recipients will not divulge to others facilitated disclosure. A participant stated, "I could talk about how I felt with confidence because I felt that they wouldn't be telling, divulging." Another stated: "Not everyone keeps quiet. If I say it here, the whole world will know."

Attentive (estar al pendiente, estar al tanto).: Relating to support, *estar al pendiente* indicates being attentive, watchful, or up-to-date with the participant's needs out of concern and caring. For example, a participant disclosed to her daughter "because she is with me, cares for me, watches over me. … She asks about how I'm doing, what I've done, what I ate, everything. She is watchful over me." Another participant explained why she selectively disclosed to one daughter, "Because she has always been the closest to me. If something comes up, I can call her right away. I have more communication with her. She knows everything."

Quality of the relationship

Trust and familiarity (por la confianza).: Having *confianza* in a particular person demonstrates closeness and familiarity and indicates trust, faith, and confidence in the close other. Participants often selected disclosure recipients based on *confianza* shared with these individuals, such that they perceived the information would not be misused or they would not be judged. When asked to whom she disclosed, a participant answered, "With my three daughters I have great trust." Another participant stated that he would disclose "to the people with whom I have trust. How could I be telling the whole world? No! To them, because I already established trust."

Support received (el apoyo que me dan).: Some participants explicitly expressed that they disclosed their depression because of support and help they previously received from specific individuals. One participant stated:

> I think it's because of the support they give me. My sisters say, 'Give it your all you got! Come on sister, take care of yourself!' They say that, or a comforting word. I feel good that way; talking with them and sharing.

Another participant selectively disclosed to her son: "I can tell him everything. He does not give me the solution because he can't give it to me, but at least he supports me. He says, 'Don't worry, mom. There will be better times.'"

Shared experience and reciprocity (tambien sufren de esta cosa).: Disclosure was facilitated by the shared experience of depression and the reciprocity of encouragement. Some participants felt compelled to disclose "because they tell me about theirs." "I wouldn't tell anyone until my friends started to tell me that they suffered from the same thing. That's when I told them, 'Well, the doctor also told me that I have depression.'" Disclosures emerged out of reciprocity and giving advice. One participant explained, "She too. She shares with me. I give her advice. And that's how we go about it". One participant described her advice: "No, honey. I've also felt that way. But we must to give it our all."

Barriers to depression diagnosis disclosure

Although most participants disclosed their depression to at least one person, they described concerns that they pondered before disclosing.

Individual needs

Losing face and shaming (se van a reír de uno).: When first asked about whether they felt embarrassment, shame, or fear of discrimination with talking about their depression with important others, many participants expressed not feeling that way and that those things would not be barriers to depression disclosure. Yet later in the interview, many of those same participants expressed fears related to diminished self-image and shame if they disclosed indiscriminately or to certain individuals. A participant said, “I feel like they’ll laugh at me. I’d rather keep quiet.” Another stated, “I try not to tell anybody. I’m kind of ashamed and I don’t want them to think I’m crazy.” Some participants described fear of losing face if they showed a sign of weakness. For example, one participant feared losing her credibility as a pastor if she disclosed her depression. “I’m in front of them all. They respect me. Even if I feel it inside, I won’t demonstrate it to them.” Another participant described the vulnerability of self-image in society: “One wants to present another face. … Don’t want others to find out that you’re depressed because you’ll get discarded!”

Being manly (por el machismo).: For men, machismo (i.e., masculine pride; strong sense of being manly and self-reliant) was described as a barrier to depression disclosure related to their need to maintain gender role expectations. Regarding his fears of disclosure, a participant stated, “Society has us in a place where the man has to endure more. It’s not the same seeing a woman cry than seeing a man cry. Society views that very differently.” A female participant commented on men’s machismo as a barrier:

> Men think that their machismo will diminish. Women look for ways out; talk with friends. If men talk with their closest friends, they’ll talk about their machismo. They’ll never find an answer. If they’d surrender a little, they’d feel better.

A male participant made a gender distinction regarding the disease: “Men don’t talk about depression due to their machismo. They say ‘it’s a woman’s illness.’”

Private person (soy reservada).: Some participants described the personality trait of being private as a barrier to disclosure. One participant stated, “Nobody knows. I’m very reserved”. Some participants attributed being a private person to their upbringing and culture. “I’m too private to be telling my things to others. I don’t like that. … My mother was very private about everything. In those times there was more privacy about everything. That’s how it was in Guadalajara.” Another participant stated, “No, well why would we be talking about that? … I was brought up this way, to endure, suffer my own things, and not be telling it.”

Recipient’s characteristics

Nothing they can do (no pueden hacer nada).: Some participants expressed that there is no point in sharing about their depression if there is nothing that others can do. In particular, one participant said:

> But I also don’t want to tell them anything. They ask how I’m doing. I say, “I’m fine. I feel fine”. But I don’t want to be worrying them with the same thing, that I’m depressed. … I worry them because I know they feel bad and they can’t do anything.

A related perception is that the recipient is too busy and does not have time to do anything about the participant’s plight. Some participants mentioned their loved ones’ busy lives in the context of not wanting to worry them. A participant explained, “If I tell my daughter who is the busiest, what can she do? Nothing! Yet I will worry her”. Another participant stated, “No, well, they’re very busy.”

Rejection and disinterest (al ver su rechazo).: Some participants avoided talking about their depression with specific individuals who demonstrated disinterest, lack of involvement, or care. One participant stated, “They’re my kids; they should be more interested in my health. They could care less!” Another explained, “After feeling the rejection, you don’t feel like saying anything.”

Participants avoided disclosure to forestall complaints or criticism from others. A husband’s reaction was, “Oh, you believe that bull! It’s not true! What they want is to make you more crazy!” Another participant’s husband reacted as if her depression was a nuisance:

> He tells me not to keep telling him that I have depression. I’m talking to him and he looks the other way. I ask him if he’s listening to what I said and he tells me, ‘I heard you. What do you want me to think? You already have it; too bad.’

Quality of the relationship

Cause no suffering (no motirficarlos).: Participants were concerned about the worry and emotional suffering that their depression might inflict on others, especially their adult children. A participant explained that disclosing to her children “would have caused them stress because they would have felt bad. So if I tell them, and I don’t want to return to Guatemala, it’s like making them suffer. We don’t want to hurt our loved ones.” Another participant stated, “My children worry and suffer because of that. And even though I felt ill, I didn’t say anything so they wouldn’t worry about me.” Participants often delayed disclosure. One participant stated, “I told them after some time had passed. I said, ‘I didn’t want to worry you.’”

Negative experience with disclosure (perdí el interés).: An unfavorable response to a previous disclosure sometimes discouraged future disclosures. A participant described the body language of her uninterested daughter-in-law as she disclosed a different illness. Because the daughter-in-law seemed uninterested, the participant refrained from disclosing any personal information about herself, including her depression. Another participant described a similar negative experience: “You lose interest in making further comments about your mood or your health.”

Discussion

Based on 35 in-depth interviews with primarily Spanish-speaking older Latin@, we found that depression diagnosis disclosure is both a liberating and stressful experience. A cultural framework of 15 themes emerged, characterized by eight facilitators and seven barriers regarding disclosure: (a) the individual's needs; (b) the characteristics of the potential recipient; or (c) the quality of the individual–recipient relationship.

Facilitators

Individual needs that facilitated disclosure included a cathartic experience (*es un desahogo*), needing help (*necesito ayuda*), and depression awareness (*antes no sabía nada*). *Desahogo* is consistent with prior work on Latin@s in clinical interviews, online cancer support groups, and supportive counseling for depression (Changrani et al., 2008; Collado, Long, MacPherson, & Lejuez, 2014; Interian, Allen, Gara, & Escobar, 2008; Vázquez-Montilla, Reyes-Blanes, Hyun, & Brovelli, 2000). Catharsis has been cited in research on HIV disclosure (Derlega, et al., 2004) and personal secrets (Afifi and Steuber, 2009). Needing help has been identified in work with Chinese immigrants with mental illness wherein help included monitoring of symptoms and making helpful suggestions (Chen, et al., 2013).

Depression awareness and severity helped respondents identify their symptoms and share with others. Research suggests that individuals will engage in emotional disclosure when experiencing distress (Stiles, 1987); the more distressing an event, the more likely individuals are to share their experiences (Luminet, Bouts, Delie, Manstead, & Rimé, 2000). Yet in a diverse racial and ethnic sample of persons living with mental illness, symptom distress was positively correlated with secrecy, not disclosure (Chronister, et al., 2013). In another study of primarily nonminority participants with schizophrenia, those who reported very good current mental health were more open about their schizophrenia diagnosis (Pandya, Bresee, Duckworth, Gay, & Fitzpatrick, 2011).

The recipient's characteristics also played a role in disclosure. Participants sought individuals who would not divulge their private matters to others, although it is unclear if this concern was due to stigma- or privacy-related motivations. Disclosure was also facilitated by attentiveness (*estar al pendiente*), characterized as the recipient's ongoing watchfulness to make sure that the individual's needs were met. Attentiveness is characterized as aspects of support in research on aging (Hawley and Chamley, 1986) and caregiving in Mexico City (Mendez-Luck, Kennedy, & Wallace, 2009); in turn, perceived social support has been positively related to disclosure of mental illness (Bos, Kanner, Muris, Janssen, & Mayer, 2009). This demonstrates the challenge of separating often interrelated categories such as recipients' characteristics and relationship quality.

Attentiveness was closely aligned with the relationship quality as demonstrated by trust and familiarity: *confianza* as an important building block in fomenting supportive relationships, is prevalent in the literature related to Latin@ relational ties, indicating an allocentric cultural orientation (Añez, Paris, Bedregal, Davidson, & Grilo, 2005; Cervantes and Castro, 1985; Keefe, Padilla, & Carlos, 1979). Trust in mental illness disclosure was also observed among Chinese immigrants such that the circle of confidence was defined by appraisal of *ganqing* (affection and trust) among participants' network of family and relatives (Chen, et al., 2013). Thus without trust, disclosure is less likely to occur.

Quality of support received (*el apoyo que me dan*) is not the opposite of rejection and disinterest (as listed under disclosure barriers), but signals that help is needed. Previous research corroborates the positive relationship between mental illness disclosure and social support (Bos, et al., 2009; Chronister, et al., 2013). Greater quality of social support was associated with HIV status disclosure and mental health treatment among Latin@s (Hansen, Fuentes, & Aranda, 2017; Zea, et al., 2005).

Barriers

Individual needs that discouraged disclosure included losing face and shaming (*se van a reir de uno*), being manly (*por el machismo*), and being a private person (*soy reservada*). Although no participants used the word stigma, they described shame and fear of diminished self-image as disclosure barriers. Perhaps they do not use the word with ease in their own vocabulary, or find it more acceptable to describe stigma in more culturally acceptable words (embarrassment, shame) or by articulating fear of being laughed at or discounted. Similarly, Chinese immigrants expressed shame and fear of losing face as reasons to conceal mental illness (Chen, et al., 2013). Perceived stigma was negatively correlated with disclosure (Bos, et al., 2009), and was a disclosure barrier among individuals not motivated by the needs and well-being of others (Garcia and Crocker, 2008).

Men and women recognized *machismo* as a disclosure deterrent. In Latin@ cultures, *machismo* is the cultural expectation that men are “strong, in control, and the providers for their families” (Marín and Marín, 1991, p. 16). Shattel et al. (2008) found that culturally determined gender roles influenced perceptions about mental illness and men's willingness to disclose in the context of seeking treatment. The personal attribute of “always being a private person” was also a barrier; discussed as transcending the disclosure situation and crossing over to other private concerns. Thus, exploring personal attributes that indicate a more introverted rather than extroverted personality might explicate factors that influence disclosure.

Related to target characteristics, participants struggled to disclose if they felt there was nothing that their loved one could do (*no pueden hacer nada*). This reflects concern that the recipient does not have the resources (time, monetary, competencies) to exert a difference, even if disclosure occurs. Rejection and disinterest (*rechazo*) symbolized some participants' reality regarding negative social interactions and interpersonal conflicts. Rejection and disinterest may indicate a lack of emotional support (Cohen and Hoberman, 1983); research has shown a negative correlation between emotional support and secrecy regarding mental illness (Chronister, et al., 2013).

Concerns about how disclosure might adversely affect loved ones (cause no suffering, *no motificarlos*) illustrate the personal interdependence characteristic of allocentric cultures (Marin and Triandis, 1985), and is consistent with research on HIV disclosure among Latin@ men (Mason, Marks, Simoni, Ruiz, & Richardson, 1995) and Chinese immigrants who did not disclose their mental illness to avoid burdening others (Chen, et al., 2013). As a cultural script or pattern of social interaction, participants determined that the culturally appropriate response to disclosure was to offer assistance, thus creating a sense of burden. Our participants also demonstrated the Latin@ cultural script of *simpatía*. To be perceived as likeable and easy-going or *simpatico(a)*, a person will show "certain levels of conformity and an ability to share in other's feelings" (Triandis, Marin, Lisansky, & Betancourt, 1984, p. 1364). In a self-sacrificing manner, persons may withhold or delay disclosure to maintain harmony and agreement (Marín and Marín, 1991; Triandis, et al., 1984).

These data demonstrate that depression diagnosis disclosure is a dynamic, multidimensional process based on cultural norms and expectations similar to the depression experiences documented by Camacho and his associates (Camacho et al., 2017). Similar to previous research (Chaudoir and Fisher, 2010; Greene, 2009), participants tested their disclosure and evaluated whether or not they received a favorable reaction. Subsequent disclosure, if any, was based on the reaction to the initial disclosure.

Implications

Although none of the respondents directly cited stigma as a reason for trepidation regarding disclosure, participants used related terms such as shame and fear of being called "crazy." This is an important consideration for clinicians, administrators, researchers, and policy makers concerned about the underutilization of services and lack of treatment adherence among Latinos. Previous work indicates that perceived stigma can influence help-seeking behaviors and adherence to mental health care (Cabassa, Hansen, Palinkas, & Ell, 2008; Camacho, et al., 2017; Alejandro Interian, et al., 2007; Pincay and Guarnaccia, 2007).

Avoiding disclosure out of concern for others is not unique to Latin@s; thus, our findings may have implications for other groups. Studies have found that fear of burdening family members and caregivers affects illness disclosure among persons with terminal illness, HIV, and among older adults in general (Cahill, Lewis, Barg, & Bogner, 2009; Horne and Payne, 2004; Mason, et al., 1995). Other-protective reasons for not telling parents about HIV infection (e.g., "I didn't want my mom to worry.") are more prevalent among Latin@s than non-Hispanic Whites. Research has indicated that perceived burdensomeness occurs more often among older adults compared to younger adults (Foster, 2003), perhaps due to perceptions of diminished functioning and increased dependency.

The relationship among trust (*confianza*), previous disclosure experiences, and disclosure in general is also exemplified in the observed discrepancy between participants' initial reports (opinions and depth) of not feeling embarrassment, shame, or fear and what they shared toward the end of the interviews about fears related to diminished self-image and losing face. The initial concealment of stigma-related feelings and related impact on disclosure behavior might have been an effort to hide vulnerabilities until more trust had been established with the interviewer.

This study has important clinical implications, as disclosure seemed to have substantial therapeutic value in the form of catharsis (*desahogo*). Thus, disclosure could provide a viable intervention for improving psychological well-being among Latin@ older adults. Further, the older adult's venting may signal to the disclosure recipient the need to provide social support and linkage to resources. Future research is needed to inform mental health treatment with older Latin@s on how to manage depression disclosure so as to optimize the potential benefits.

Limitations as opportunities

This exploratory study used qualitative methods, thus any inferences regarding representativeness should be interpreted with caution. We cannot say that disclosure occurred at one point in time (a discreet event) or incrementally during several encounters (an ongoing process). Future research should include more participation from men, and attempt to differentiate among subgroups of Latin@s with different levels of service utilization and access to care.

Conclusion

Depression disclosure is a culturally-ladened experience that entails both emotional and rational thinking around whom to disclose and why. How an individual negotiates truth-telling of a psychiatric diagnosis is a dynamic, multidimensional process that entails weighing the pros and cons of disclosure. Knowledge of Latin@ older adults' perspectives and experiences with disclosure can inform culturally sensitive strategies to support older Latin@s with depression.

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Table 1.

Sample characteristics ($n = 35$).

Variable	*M* (*SD*) or *n* (%)
Age	71.11 (7.26)
Female	30 (85.7)
Nativity	
U.S.-born	5 (14.3)
Immigrant	30 (85.7)
Preferred language	
Spanish	31 (88.6)
English	4 (11.4)
Marital status	
Married or domestic partnership	14 (40.0)
Widow	10 (28.6)
Separated or divorced	9 (25.7)
Single or never married	2 (5.7)
Living arrangement	
Alone	13 (37.1)
With spouse or other family	22 (62.9)
Education	
8th grade or less	27 (77.1)
Some high school	2 (5.7)
High school or higher	6 (17.2)
Hamilton Depression Rating Scale (baseline)	23.77 (4.57)
Study intervention condition	
Problem-solving therapy	23 (65.7)
Enhanced usual care	12 (34.3)

Table 2.

A cultural framework describing facilitators and barriers to mental health disclosure

Theme	Representation	Definition
Facilitators		
Individual needs		
Cathartic experience	*Es un desahogo*	The need to release one’s pent-up emotions; the need to have a cathartic experience
Needing help	*Necesito ayuda*	The need or desire for tangible help or assistance
Depression awareness and severity	*Antes no sabía nada*	The lack of knowledge of depression, its nature and severity
Recipient (“the other”) characteristics		
Won’t divulge	*No lo anda contando*	The expectation that the other will not divulge private matters
Attentive	*Estar al pendiente*	The other is attentive, watchful, aware
Quality of the relationship		
Trust and familiarity	*Por la confianza*	The confidence that the other does not misuse disclosed information
Support received	*El apoyo que me dan*	The past experience of the support and help they received from the other
Shared experience and reciprocity	*Sufren de esta cosa*	The reciprocity or mutually shared experience of depression
Barriers		
Individual needs		
Losing face and shaming	*Se van a reir de uno*	The fear of public shaming due to “being crazy”
Being manly	*Por el machismo*	Masculine pride, being manly and self-reliant
Private person	*Soy reservada*	The attribute of being a private person for all matters
Recipient characteristics		
Nothing they can do	*No pueden hacer nada*	The notion that the other cannot do anything, or are too busy
Rejection and disinterest	*Al ver su rechazo*	The signs of the other’s rejection and disinterest about the problems
Quality of the relationship		
Cause no suffering	*Para no mortificarlos*	The fear of causing the other stress and suffering
Negative experience with disclosure	*Perdí el interés*	Previous negative experiences thwart interest in disclosure