

THE UNFOLDING OF DEPRESSIVE SYMPTOMS, DISEASE SELF-
MANAGEMENT, AND TREATMENT UTILIZATION FOR LATINA
ADOLESCENTS

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Latina adolescents are more likely to suffer from depressive symptoms and less likely to receive mental health services for depression than their White peers, and this mental health disparity is poorly understood. The purpose of this dissertation study is to describe how Latina adolescents experience and seek mental health services for their depressive symptoms. The dissertation includes three components. The first is an integrative literature review to determine which cultural stressors are associated with depressive symptoms among Latino/a youth. The results indicate that discrimination, family culture conflict, acculturative and bicultural stress, intragroup rejection, immigration stress, and context of reception are associated with depressive symptoms in this population. The second and third components were based on interviews with 25 Latinas (ages 13-20) who experienced depressive symptoms during adolescence. In the second component, a content analysis was conducted to determine cultural stressors experienced by contemporary Latinas living in a tumultuous sociopolitical climate in the United States. The stressors included (a) pressure to succeed, (b) parental oversight, (c) being treated differently, and (d) fears of deportation. In the third component, grounded theory methods were used to develop a theoretical framework to describe the process by which Latina adolescents self-managed and sought treatment for depressive symptoms. In

this framework, participants shared a psychosocial problem labeled *Being Overburdened and Becoming Depressed*. They responded to this problem through the psychosocial process labeled *Getting a Grip on My Depression*, which consisted of five phases: 1) *hiding my depression*, 2) *keeping my depression under control*, 3) *having my depression revealed*, 4) *skirting treatment for my depression*, and 5) *deciding to move on from depression*. The Latino family, peer groups, and mainstream authorities influenced the participants' experiences. The process of experiencing, self-managing, and seeking treatment for depressive symptoms for Latina adolescents is both similar to and unique from the processes by which other groups of adolescents experience depressive symptoms. These results will contribute to the development of culturally-sensitive strategies to prevent, identify, and treat depressive symptoms in Latina adolescents.

Claire Burke Draucker, PhD, RN, FAAN, Chair

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LIST OF ABBREVIATIONS

Abbreviation	Term
AA	African American
BSS	Bicultural Stress Scale
CDC	Centers for Disease Control and Prevention
DACA	Deferred Action for Childhood Arrivals
DD	Dysthymic Disorder
DSM-V	Diagnostic and Statistical Manual 5th Edition
HIPAA	Health Information Portability and Accountability Act
HSI-AV	Hispanic Stress Inventory-Adolescent Version
IAM	Interactive Acculturation Model
IRB	Institutional Review Board
MDD	Major Depressive Disorder
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
SAMHSA	Substance Use and Mental Health Services Administration
YRBSS	Youth Risk Behavior Surveillance System

CHAPTER 1

Introduction

This chapter serves as an introduction to the dissertation research. The chapter includes a discussion of the significance and background of the topic, theories relevant to the study, the purpose and specific aims of the study, a description of the study methods, and a brief summary of chapters 2-5.

Significance and Background

Prevalence of Depressive Symptoms

Latino/a (both male and female) adolescents experience significantly higher rates of depressive symptoms than Caucasian and African American (AA) adolescents. In particular, Latina (female) adolescents experience depressive symptoms at higher rates than Latino (male) adolescents and Caucasian and AA girls. In 2015, The Youth Risk Behavior Surveillance System (YRBSS) revealed that 46.7% of Latina adolescents reported feeling sad and hopeless on a daily basis, in comparison to 24.3% of Latino adolescents (Centers for Disease Control and Prevention [CDC], 2016). These rates were also significantly higher than for Caucasian adolescent girls (37.9%) and AA adolescent girls (33.9%; CDC, 2016). Latino/a adolescents also suffer from major depressive disorder (MDD) at a slightly higher rate than Caucasian and AA youth (Avenevoli, Swendsen, He, Burstein, & Merikangas, 2015; Substance Abuse and Mental Health Services Administration [SAMHSA], 2015). According to SAMHSA (2015), 25.7% of Latina adolescents reported having experienced an episode of Major Depressive Disorder (MDD) in their lifetime, in comparison to 25.2% of

Caucasian and 22.1% of AA adolescent girls in 2014. Although Latina adolescents have similar lifetime incidence of MDD as other groups of young women, they have higher rates of depressive symptoms, and those experiencing depressive symptoms, although they may not meet the criteria for an MDD diagnosis, still experience clinically significant levels of psychological distress and functional impairment (Wesselhoeft, Sørensen, Heiervang, & Bilenberg, 2013). Table 1.1 summarizes the percentage of the population of Latino/a, AA, and Caucasian adolescents who experience depressive symptoms and MDD.

Table 1.1

Percentage of Adolescents with Mental Health Concerns by Ethnicity: 2014-2015

Mental Health Concern	Latino/a		Non-Latino/a AA		Non-Latino/a Caucasian	
	Boys	Girls	Boys	Girls	Boys	Girls
Depressive Symptoms (CDC, 2016)	24.3	46.7	17.6	33.9	19.2	37.9
Lifetime MDD (SAMHSA, 2015)	9.7	25.7	6.7	22.1	9.5	25.2

Significance

Depressive symptoms among Latina adolescents are associated with significant health-related consequences including suicidality. Psychological vulnerabilities, such as depressive symptoms, contribute to the high rates of suicide attempts by Latina adolescents (Romero, Wiggs, Valencia, & Bauman, 2013; Zayas, Lester, Cabassa, & Fortuna, 2005), and data from the 2015 YRBSS demonstrate that rates of suicidal ideation and suicide attempts in Latina adolescents mirror trends of depressive symptoms in this population (CDC,

2016). In 2015, 25.6% of Latina adolescents reported suicidal ideation, and 15.1% reported a suicide attempt in the past year (CDC, 2016). In comparison, 12.4% of Latino adolescents reported suicidal ideation, and 7.6% reported a suicide attempt. The rate of suicidal ideation in Latina adolescents was higher than that of Caucasian (22.8%) and AA (18.7%) adolescent girls, and the rate of suicide attempt was higher in Latina adolescents than in Caucasian (9.8%) and AA (10.2%) girls in the same age group (CDC, 2016). Table 1.2 reflects the percentage of Latino/a, AA, and Caucasian youth who experienced suicidality in 2015. In addition to suicidality, depression in Latina adolescents is associated with other risk behaviors such as cigarette smoking (Lorenzo-Blanco, Unger, Ritt-Olson, Soto, & Baezconde-Garbanati, 2011; Nezami et al., 2005), substance use (Schwartz et al., 2015), and rule-breaking behavior (Cano et al., 2015; Delgado, Updegraff, Roosa, & Umaña-Taylor, 2011). Depression in Latina adolescents is therefore not just a highly prevalent problem but a problem associated with serious health-related consequences.

Table 1.2

Percentage of Adolescents with Suicide-related Events by Ethnicity in 2015

Suicide-related Event	Latino/a		Non-Latino/a AA		Non-Latino/a Caucasian	
	Boys	Girls	Boys	Girls	Boys	Girls
Suicidal Ideation (CDC, 2016)	12.4	25.6	11	18.7	11.5	22.8
Suicide Attempt (CDC, 2016)	7.6	15.1	7.2	10.2	3.7	9.8

Cultural stressors and depression. Latino/a adolescents experience both universal and cultural stressors. Adolescents in the US, regardless of their race or ethnicity, experience common stressors that can contribute to the

development of depressive symptoms (Stein, Gonzalez, & Huq, 2012). These stressors, referred to as universal stressors (Stein et al., 2012), include family conflict (Kelly et al., 2016; Restifo & Bogels, 2009), peer victimization (Hawker & Boulton, 2000; Kelly et al., 2016; Stapinski, Araya, Heron, Montgomery, & Stallard, 2015), and economic difficulty (Santiago, Wadsworth, & Stump, 2011). In addition to these universal stressors, Latino/a adolescents also experience cultural stressors, which are unique stressors that are experienced as a result of being a member of a certain ethnic group (Cano et al., 2015; Cervantes, Cardoso, & Goldbach, 2015; Garcia-Coll et al., 1996; Stein et al., 2012). Discrimination (Cano et al., 2015; Lorenzo-Blanco et al., 2011; Potochnick, Perreira, & Fuligni, 2012; Potochnick & Perreira, 2010; Schwartz et al., 2015; Schwartz et al., 2014), family conflict over cultural values (Cervantes et al., 2015; Cervantes, Fisher, Cordova, & Napper, 2012; Lorenzo-Blanco, Unger, Baezconde-Garbanati, Ritt-Olson, & Soto, 2012; Lorenzo-Blanco & Unger, 2015), perceived lack of opportunity (Cano et al., 2015; Schwartz et al., 2015; Schwartz et al., 2014), and immigration difficulties (Cervantes et al., 2015; Cervantes et al., 2012; Potochnick & Perreira, 2010) are cultural stressors that are associated with the development of depressive symptoms in Latino/a adolescents. Several studies have also demonstrated that young Latinas experienced increased levels of depressive symptoms in comparison to young Latino men due to increased family-related stressors (Hankin, Mermelstein, & Roesch, 2007) and discrepancies between parent and daughter beliefs on traditional gender roles (Céspedes & Huey, 2008; Piña-Watson, Castillo, Ojeda, & Rodriguez, 2013).

Mental health treatment and utilization. Latino/a adolescents often lack access to and underutilize mental health services. In 2014, 19.9% of Latinos/as were uninsured. This rate is higher than both African-American (11.8%) and Caucasian (7.6%) populations (Smith & Medalia, 2015). Without health insurance, individuals often underutilize healthcare services (Freeman, Kadiyala, Bell, & Martin, 2008; Vega, Kolody, & Aguilar-Gaxiola, 2001). Although Latinos/as often have a positive perception of mental health treatment (Chandra et al., 2009; Karasz & Watkins, 2006; Probst, Laditka, Moore, Harun, & Powell, 2007; Shim, Compton, Rust, Druss, & Kaslow, 2009), they are less likely than Caucasians (Alegria et al., 2008; Cummings & Druss, 2011; Garland et al., 2005; Hough et al., 2002; Miranda & Cooper, 2004) and AAs (Cummings & Druss, 2011) to receive treatment from formal mental health care providers. For Latino/a adolescents suffering from MDD in 2015, only 34% received mental health treatment for depression, in comparison to 45% of Caucasian adolescents and 40% of African-American adolescents (SAMHSA, 2016). When Latinos/as do seek treatment for mental health concerns, they are more likely to see a primary care provider than a specialized mental health provider (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2003; Garland et al., 2005; Vega et al., 2001) and are less likely to be prescribed antidepressant medications (Cummings & Druss, 2011; Kirby, Hudson, & Miller, 2010; Miranda & Cooper, 2004) or receive psychotherapy (Chen & Rizzo, 2010) than Caucasian Americans. Although it is recognized that Latino/a adolescents experience disparities in receiving mental health treatment, strategies are not

well established to facilitate the utilization of mental health services in this population (Alegría et al., 2008; Davidson, Soltis, Albia, de Arellano, & Ruggiero, 2015).

While several evidence-based treatments are available for the treatment of adolescent depression, few are adapted to the unique needs of Latino/a adolescents. Current evidence indicates that cognitive behavioral therapy, individual interpersonal psychotherapy, and antidepressant medications are effective treatment options for adolescents who are depressed (Clark, Jansen, & Anthony Cloy, 2012; David-Ferdon & Kaslow, 2008; TADS Team, 2007). Due to the lack of empirical testing in the Latino/a population, however, these treatments are not considered well established for the treatment of depression in Latino/a adolescents specifically (Huey & Polo, 2008; Hooper, Mier-Chairez, Mugoya, & Arellano, 2016). Many experts agree that cultural adaptation of evidence-based treatments is necessary since culture affects both mental health diagnosis and treatment (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Bernal & Scharró-del-Río, 2001; Canino & Alegría, 2008; Comas-Diaz, 2006; Hooper et al., 2016). Because Latino/a adolescents in the US live within a unique sociocultural environment that affects the development of mental health problems and mental health utilization patterns (Davidson et al., 2015; Goldston et al., 2008), treatments for depression need to be adapted for use in the Latino/a population (Bernal et al., 2009; Bernal & Scharró-del-Río, 2001; Chu, Leino, Pflum, & Sue, 2016; Davidson et al., 2015; Lau, 2006). If healthcare providers rely on standard treatments for Latino/a adolescents who are depressed without

understanding the specific cultural challenges that they face in seeking and utilizing treatment, it is likely that the treatment will be compromised (Chu et al., 2016).

When Latina adolescents seek help for their depressive symptoms, they are more likely than AA and Caucasian adolescents to rely on informal sources (Garland et al., 2005). Folk healers, religious leaders, and family members often provide informal support to Latino/a adolescents experiencing depressive symptoms (Cauce et al., 2002; Garland et al., 2005; Lorenzo-Blanco & Delva, 2012; Rew, Resnick, & Blum, 1997). These informal support networks are protective against depressive symptoms in young Latinos/as (Almeida, Subramanian, Kawachi, & Molnar, 2011; Lorenzo-Blanco et al., 2012; S. R. Potochnick & Perreira, 2010; Rivera, 2007). Adapting mental health treatments to this population thus might draw on factors inherent in informal support networks that contribute to prevention and recovery from depression (Davidson et al., 2015).

Few studies have directly described how Latino/a adolescents experience depression from their own perspectives. In outlining the research agenda for depression in Latino/a adolescents, Castañeda (1994) called for an understanding of the subjective world of adolescents with depression. Since this time, many research studies, as described above, have identified specific factors associated with depressive symptoms in Latino/a adolescents, but the subjective experiences of Latina adolescents with depressive symptoms have not been explored in-depth. Several qualitative studies have addressed Latinos'/as'

perceptions and knowledge of depression (Barrera, Schulz, Rodriguez, Gonzalez, & Acosta, 2013; Fornos et al., 2005; Garcia & Lindgren, 2009) and barriers to mental health treatment for Latinos/as (Karasz & Watkins, 2006; Uebelacker et al., 2012). One qualitative study examined the etiology of depression in Latina adolescents with depression (Lopez-Morales, 2008), but to my knowledge, no studies have specifically examined how depressive symptoms unfold over time for Latina adolescents. Additionally, the processes by which this population seeks and utilizes mental health services or alternatively manages depressive symptoms on their own or with the help of informal supports have not been well described (Lopez, Bergren, & Painter, 2008).

Theoretical Perspectives

Theory is used in qualitative research to sensitize the researcher to the problem and provide a context in which the phenomenon can be viewed (Sandelowski, 1993). Several theories have informed the development of this qualitative study including symbolic interactionism, constructivism, the transactional model of stress and coping (Lazarus & Folkman, 1984), biological theories of stress (Nestler et al., 2002), and the integrative acculturation model (Bourhis, Moise, Perreault, & Senecal, 1997). The current study did not test these models, but they did inform how the principal investigator viewed the phenomenon of depressive symptoms for Latina adolescents.

Symbolic Interactionism and Constructivism

Symbolic interactionism and constructivism form the philosophical foundation of this qualitative research study. Under both symbolic interactionism

and constructivism, truth is seen as relative, and multiple individual realities are acknowledged (Blumer, 1969; Charmaz, 2014). According to symbolic interactionism, individuals are actors in their world and build meaning in their lives through practical interactions with others. Individuals perform actions, interpret others' language and responses to their actions, and then continue to act based on those interpretations (Blumer, 1969). Constructivism further posits that individuals construct meaning in their lives based on their past personal experiences (Charmaz, 2014). Through research, truth is constructed, rather than discovered, and the research itself is a social construction (Charmaz, 2014). The researcher and the participant both interact with each other based on knowledge from past experiences, interpret each other's behavior and language, and respond according to their own interpretations. This interaction influences the research process and, thus, the findings of the research study.

Transactional Model of Stress and Coping

The transactional model of stress and coping (Lazarus & Folkman, 1984) describes the process that individuals undergo when experiencing and coping with psychological stress (see Figure 1.1). According to this model, psychological stress occurs only after an individual appraises an event as threatening. Individuals first engage in primary appraisal of the event, which involves the evaluation of the significance of the potential stressor. The individual also engages in secondary appraisal, which is the evaluation of the controllability of the potential stressor and availability of resources to overcome the potential stressor. If an individual feels that the event is threatening and that they do not

have the resources to overcome the event, then psychological stress is experienced, and the situation that contributed to that perception is considered a stressor (Lazarus & Folkman, 1984).

Once psychological stress is experienced, the individual engages in coping, which includes cognitive and behavioral efforts to master, reduce, or tolerate the internal and/or external demands that are created by the stressor (Lazarus & Folkman, 1984). According to this model, coping can take two different forms: problem management or emotional regulation strategies. Problem management strategies are directed at changing the stressful transaction, while emotional regulation is aimed at changing one's thoughts or feelings about a stressful transaction (Lazarus & Folkman, 1984). Depending on the nature of the stressor and application of the coping strategy, coping strategies can be successful and adaptive or unsuccessful and maladaptive. If the coping strategy is maladaptive, negative outcomes may result in the form of compromised well-being, impaired functional status, or negative health behaviors (Lazarus & Folkman, 1984).

The transactional model of stress and coping assumes that the individual and the environment are in constant interaction with each other, and it is from these transactions between the individual and environment that stress can develop (Lazarus & Folkman, 1984). The model also assumes that stress is a process that constantly changes from the interplay between individual and environment and varies from individual to individual (Lazarus & Folkman, 1984). More recent modifications to the model include the addition of dispositional

coping styles and social support as moderators of the relationships between appraisal, coping, and outcomes (Wethington, Glanz, & Schwartz, 2015).

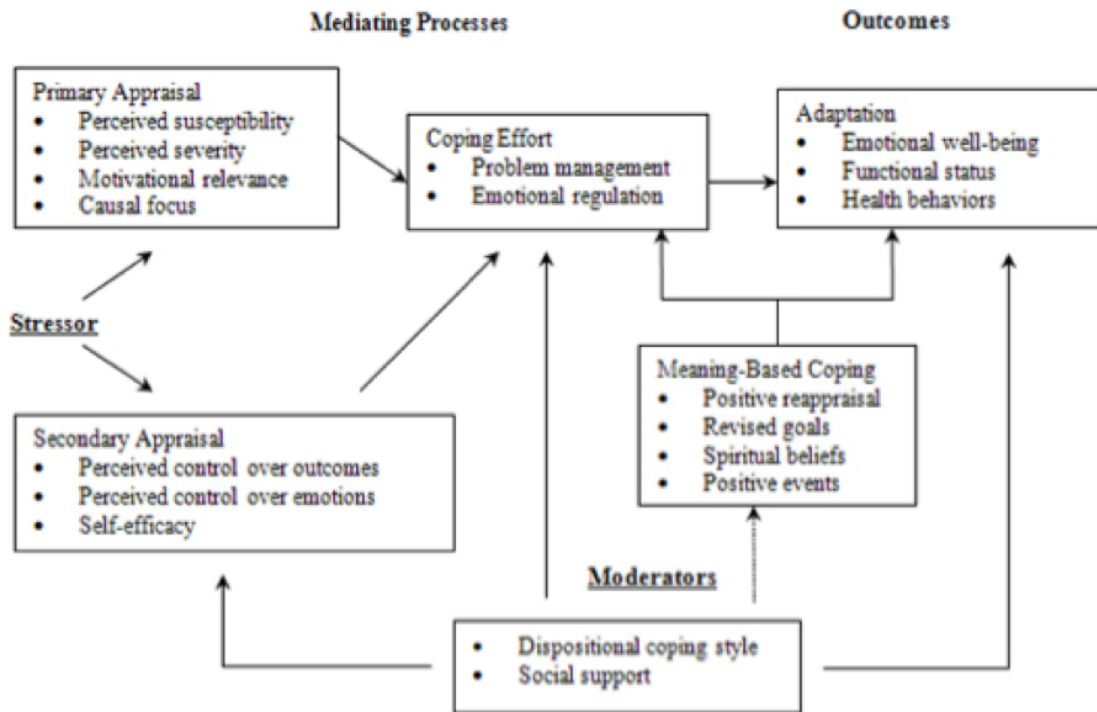


Figure 1.1. Transactional Model of Stress and Coping (Wethington et al., 2015)

Biological Theories of Stress

Biological theories related to the neurological mechanisms of depression have been primarily derived from research in adult populations. From this research, several mechanisms by which depression develops have been uncovered. One of the prevailing hypotheses is that when chronic psychological stress, as described above, is experienced, the body activates the Hypothalamic-Pituitary-Adrenal (HPA) Axis and releases epinephrine and glucocorticoids to aid in the fight or flight response (Nestler et al., 2002). This response can be adaptive with acute stress, but when the body is exposed to chronic stress, the constant activation of the HPA axis can damage structures in the brain. Studies

have demonstrated that these physiological responses to chronic stress can lead to loss of neurons in the hippocampus, which is associated with memory and emotion, and loss of hippocampal volume has been noted in the brains of individuals suffering from depression (Nestler et al., 2002). Genetics studies have also demonstrated that possessing the short form of the 5HTT allele puts an individual at risk for altered neuronal pathways involving serotonin production (Caspi et al., 2003). The lack of serotonin can sensitize an individual to psychological stress, decreasing the threshold of stressful experiences that the individual must experience before developing depressive symptoms (Caspi et al., 2003). When individuals suffering from depression take medications that increase the availability of serotonin, their depressive symptoms often improve (Nestler et al., 2002). The combination of psychological and biological theories of stress explains how many individuals come to develop depressive symptoms.

Interactive Acculturation Model

The interactive acculturation model (IAM; Bourhis et al., 1997) was deductively formed from the unidimensional and bidimensional acculturation models. The unidimensional acculturation model (Gordon, 1964) was the first to address the phenomenon of acculturation and viewed the process as occurring on a one-way continuum. On one end of the continuum, an immigrant was unacculturated and retained all aspects of their heritage culture. On the opposite end of the spectrum, the immigrant was fully acculturated and had completely adopted all elements of the host culture. This model assumed that immigrants were constantly moving towards acculturation, which was the most adaptive

outcome. The bidimensional acculturation model (Berry, 1974) asserted that immigrants could maintain certain aspects of their heritage culture and adopt specific aspects of the host culture as they chose. Based on the combination of beliefs about heritage cultural maintenance or host culture adoption, immigrants would fall into one of the four categories of integration, assimilation, separation, or marginalization. Both of these models focus on immigrant acculturation, but they do not address host community attitudes towards immigrants or how the host and immigrant communities interact. Bourhis et al. (1997) specifically aimed to fill this theoretical gap with the IAM.

Bourhis et al. (1997) defines acculturation as “the process of bidirectional change that takes place when two ethnocultural groups come into contact with one another” (Bourhis et al., 1997, p. 370). This definition encompasses three constructs: the change in one ethnocultural group, the change in another ethnocultural group, and their contact with one another. The concepts in the IAM follow this definition of acculturation in that they address immigrant acculturation orientations, host community acculturation orientations, and the outcomes that occur when the two groups interact.

Immigrant acculturation orientations describe the immigrant’s preferences regarding acculturation and are derived from the concepts in the bidimensional acculturation model (Berry, 1974) depicted in Figure 1.2. Integration describes the immigrant’s desire to maintain key features of their heritage culture, while simultaneously adopting aspects of the host culture. Immigrants have assimilated if they relinquish their own cultural identity for the sake of adopting the cultural

identity of the host community. When immigrants wish to maintain all aspects of the heritage culture, while rejecting interactions with members of the host culture, they have separated. Anomie, or marginalization, is the rejection of both the immigrant and host culture. Individualism, occurs when immigrants would rather be identified as individuals instead of being associated with a specific culture (Bourhis et al., 1997).

Dimension 1:
Is it considered to be of value to maintain the immigrant cultural identity ?

		YES	NO
Dimension 2: Is it considered to be of value to adopt the cultural identity of the host community?	YES	INTEGRATION	ASSIMILATION
	NO	SEPARATION	ANOMIE INDIVIDUALISM

Figure 1.2. Immigrant Acculturation Orientations (Bourhis et al., 1997)

Host community acculturation orientations describe the host community members' preferences regarding immigrant acculturation orientations (see Figure 1.3; Bourhis et al., 1997). The five concepts in this domain align with the five concepts of immigrant acculturation orientations, but they consider immigrant acculturation orientations from the host community perspective (Bourhis et al., 1997). Integration occurs when the host community values the heritage culture of immigrants and accepts that immigrants adopt important features of the host culture. When the host community expects that immigrants will relinquish their

cultural identity and adopt that of the host culture, this is considered assimilation. Segregation is the distancing of the host community from the immigrant community. Exclusion describes an attitude of intolerance towards the immigrant culture, including refusal to let immigrants adopt elements of the host culture and denial of the option to retain their heritage culture. Individualism describes the perspective that people should be seen as individuals rather than as a part of a cultural group (Bourhis et al., 1997).

Dimension 1:
Do you find it acceptable that immigrants maintain their cultural identity ?

		YES	NO
Dimension 2: Do you accept that immigrants adopt the cultural identity of the host community?	YES	INTEGRATION	ASSIMILATION
	NO	SEGREGATION	EXCLUSION INDIVIDUALISM

Figure 1.3. Host Community Acculturation Orientations (Bourhis et al., 1997)

Three classifications of outcomes can result when the immigrant and the host community interact. Consensual outcomes occur when there is agreement on acculturation orientations, resulting in positive cross-cultural communication, low intergroup tension, low acculturative stress, and little discrimination (Bourhis et al., 1997). Problematic outcomes occur when there is partial agreement and partial disagreement on acculturation orientations (Bourhis et al., 1997). This is likely to lead to discrimination, cross-cultural communication difficulties,

intergroup stereotypes, and acculturative stress. Conflictual outcomes result when there are opposing views on acculturation orientations, leading to very negative stereotypes, serious discrimination, and racist attacks (Bourhis et al., 1997). The specific host and immigrant acculturation orientations and resulting outcomes are described in Figure 1.4 below.

The IAM is also situated within a political perspective. Bourhis et al. (1997) proposed that policy changes regarding immigration at the national level affect the acculturation preferences of community members at the individual level. More specifically, government decision makers enact policies that affect how the host community views immigrants and how immigrants view the host community. Immigration policies also filter down to affect how immigrants and the host community interact with one another (Bourhis et al., 1997).

Host Community: Low-Medium High vitality group	Immigrant Community: low, medium vitality groups				
	Integration	Assimilation	Separation	Anomie	Individualism
Integration	Consensual	Problematic	Conflictual	Problematic	Problematic
Assimilation	Problematic	Consensual	Conflictual	Problematic	Problematic
Segregation	Conflictual	Conflictual	Conflictual	Conflictual	Conflictual
Exclusion	Conflictual	Conflictual	Conflictual	Conflictual	Conflictual
Individualism	Problematic	Problematic	Problematic	Problematic	Consensual

Figure 1.4. Relationships between Acculturation Orientations and Outcomes (Bourhis et al., 1997)

While mid-range theories of stress (Basáñez, Dennis, Crano, Stacy, & Unger, 2014; Cervantes et al., 2012; Lorenzo-Blanco et al., 2012) and acculturation (Lorenzo-Blanco et al., 2011; Paat, 2016) have been used to describe the etiology of depressive symptoms in Latino/a adolescents, a theoretical framework that specifically reflects Latina adolescents' experiences of depressive symptoms is needed. In 2003, the Council of National Psychological Associations for the Advancement of Ethnic Minority Interests (2003) called for the development of effective models to meet the unique mental health service needs of Latinos/as in the US. The high prevalence of depressive symptoms and underutilization of mental health services by Latina adolescents calls for the development of a theoretical framework that focuses on how depressive symptoms, self-management of depressive symptoms, and mental health treatment seeking unfold in this population. Such a framework can inform the development of culturally adapted strategies to prevent, identify, and treat depressive symptoms in Latina adolescents.

Concepts and Definitions

The following terms and definitions describe the major concepts addressed in this study. Terms related to the substantive content of the study (i.e., concepts related to depressive symptoms in Latina adolescents) are described in Table 1.3. Terms related to the methods used in this study are described in Table 1.4.

Table 1.3

Terms and Definitions Related to the Substantive Focus of Study

Substantive Term	Definition
Adolescence	Generally defined as the time between 10 and 18 years of age, marked by rapid biological, psychological, and social changes, in which individuals transition from childhood to adulthood (American Psychological Association, 2002)
Cultural stressor	Stressors that are unique to members of minority ethnic groups (Stein et al., 2012)
Depressive Symptoms	"Presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual's capacity to function" (American Psychiatric Association, 2013)
Dysthymia (DD)	Depressed mood for more days than not over a period of two years with presence of two other symptoms (weight gain/loss, insomnia/hypersomnia, fatigue, psychomotor agitation/retardation, feelings of worthlessness, inability to concentrate, or recurrent thoughts of death), and significant reduction in work or social functioning (American Psychiatric Association, 2013)
Latina	Female individuals of Latin American or Spanish descent
Latino	Male individuals of Latin American or Spanish descent
Latino/a	Individuals of Latin American or Spanish descent, both male and female (United States Census Bureau, 2017)
Major Depressive Disorder (MDD)	Experiencing depressed mood or loss of pleasure for a two-week period, at least four other depressive symptoms (weight gain/loss, insomnia/hypersomnia, fatigue, psychomotor agitation/retardation, feelings of worthlessness, inability to concentrate, or recurrent thoughts of death), and significant reduction in work or social functioning (American Psychiatric Association, 2013)
Mental Health Treatment Seeking	Behavioral steps taken towards addressing a mental health problem through interpersonal interaction with someone in the health-care system (Cornally & McCarthy, 2011)
Psychological stress	The perception that occurs when an individual appraises an event as taxing personal resources and endangering well-being (Lazarus & Folkman, 1984)
Self-Management	Daily steps that individuals take to minimize the impact of a health condition on their health status (Clark et al., 1991)
Stressor	The event that leads to the individual perception of stress (Lazarus & Folkman, 1984)
Universal Stressor	Stressors that are experienced by an entire population, regardless of race or ethnicity (Stein et al., 2012)

Table 1.4

Terms and Definitions Related to the Methods of Study

Method Term	Definition
Adolescent	Young women ages 13-17
Axial Coding	The process of identifying properties and attributes of the emerging categories (Charmaz, 2014)
Constant comparison	Comparing current data with previous data to identify similarities and differences (Charmaz, 2014)
Constructivism	Philosophy describing how people construct understanding of the world through interacting with others. The research process is shaped by experiences of the researcher, participants, and their interactions with each other (Charmaz, 2014)
Credibility	The degree to which the theoretical framework is consistent with the data (Charmaz, 2005).
Focused Coding	Comparing initial codes to reveal patterns in the data and sorting codes into categories based on these patterns (Charmaz, 2014)
Grounded Theory	The systematic, yet flexible, collection and analysis of qualitative data with the goal of developing a theoretical framework that is grounded in the data (Charmaz, 2014; Glaser & Strauss, 1967)
Initial Coding	The process of examining small segments of data and expressing them as actions in the gerund verb tense (Charmaz, 2014)
Integrative Review	A method used to systematically synthesize scientific literature on a specific phenomenon to answer research questions and identify gaps in the literature (Ganong, 1987)
Originality	The freshness of the categories and their social and theoretical significance (Charmaz, 2005)
Qualitative Description	A systematic, low-inference qualitative method used to identify commonalities in narratives represented in everyday language (Sandelowski, 2000)
Resonance	Relevance of the emerging categories to individuals who have experienced the phenomenon under study (Charmaz, 2005)
Symbolic Interactionism	Philosophical paradigm that posits that humans come to know and create meaning in the world through communication and interactions with others (Blumer, 1969)
Theoretical Coding	Identifying the relationships between categories so that they can be placed into a theoretical framework (Charmaz, 2014)
Theoretical Sampling	Seeking out participants who can provide additional data that will complete and refine categories that have emerged during the coding process (Charmaz, 2014)
Usefulness	Practical utility of the theoretical framework (Charmaz, 2005)
Young Adult	Young women ages 18-21

Purpose and Specific Aims

In order to develop culturally sensitive strategies to prevent, identify, and treat depressive symptoms in this population, it is necessary to understand how depressive symptoms, self-management, and treatment seeking unfold over time from the perspective of Latina adolescents. The purpose of this dissertation study is to gain a better understanding of how Latina adolescents experience, self-manage, and receive treatment for their depressive symptoms. The specific aims of the study are to:

- 1) Determine what cultural stressors are associated with depressive symptoms for Latino/a youth by a systematic integration of the existing scientific literature;
- 2) Identify common themes in the stressful experiences of contemporary Latina young women living in a tumultuous sociopolitical climate in the US; and
- 3) Develop a grounded theory that describes how Latina adolescents experience, self-manage, and seek treatment for depressive symptoms.

Methods

Differing research methods were used to address the specific aims of this dissertation study. Integrative review methods as outlined by Ganong (1987) were used to determine which cultural stressors were associated with depressive symptoms for Latino/a adolescents in chapter 2. Integrative review methods consist of systematic strategies for querying, analyzing, and synthesizing scientific literature to answer specific research questions (Ganong, 1987).

Qualitative description methods were used in Chapter 3 to determine common cultural stressors experienced by contemporary Latina young women living in a tumultuous sociopolitical climate. Qualitative description is a low-inference qualitative method used to identify commonalities in participants' narratives using everyday language (Sandelowski, 2000). Grounded theory methods were used in Chapter 4 to develop a theoretical framework that explains how Latina adolescents experience, self-manage, and seek treatment for their depressive symptoms. Grounded theory methods are a systematic, yet flexible, method of collecting and analyzing qualitative data in order to develop a theoretical framework that reflects the data (Charmaz, 2014; Glaser & Strauss, 1967). Grounded theory frameworks explain psychosocial processes that unfold over time and place these processes within a sociocultural context (Bryant & Charmaz, 2010; Charmaz, 2014; Glaser & Strauss, 1967). Further descriptions of these methods are located in Chapters 2, 3, and 4.

Sample and Setting

Purposive sampling was used to recruit participants in this study (Charmaz, 2014; Karasz & Watkins, 2006). In contrast to random sampling, purposive sampling involves purposefully recruiting participants who possess specific experiences (Grove, Burns, & Gray, 2013). While it cannot be determined a priori exactly how many participants will be necessary in a grounded theory study, Morse (2000) suggests that 20 to 30 participants are often sufficient when conducting a qualitative study that examines a shared psychosocial process. Given that all the participants in the study experienced

depressive symptoms during adolescence within a similar sociocultural context, the sample of 25 young Latinas was sufficient for this study. During later interviews, many participants began to recount similar patterns in their experiences with depressive symptoms, indicating that theoretical saturation had also been reached (Charmaz, 2014).

Recruitment Procedures. In order to obtain narratives from Latina young women who had experienced a broad range of depressive symptoms as adolescents, had and had not experienced formal mental health treatment, and had and had not told parents or adults about their depressive symptoms, participants in this study were recruited from a variety of settings requiring different recruitment procedures. All procedures were approved by the Indiana University Institutional Review Board (IRB).

Adolescents recruited from the community. Eight adolescents were recruited from a summer camp for Latino/a adolescents, taking place each summer in Indianapolis. Participants in this group a) were ages 13-17; b) self-identified as Hispanic/Latina; c) spoke and read English; and d) were identified by camp staff as reporting depressive symptoms (Score ≥ 5) on the Kutcher Adolescent Depression Scale (KADS-11; Kutcher & Chehil, 2007). Before camp begins, all adolescents were screened for depressive symptoms with the KADS-11. Camp staff identified adolescent girls who reported depressive symptoms on the KADS-11 and verified that it was okay for the principal investigator to contact a parent of these adolescents to talk about the study in detail. If they agreed, the principal investigator called the parent to explain study and obtain verbal parental

consent over the phone. The principal investigator is proficient in the Spanish language and was prepared to explain the purpose of the study to the participants and their parents and answer questions in Spanish. The principal investigator then approached the adolescent and asked if she was interested in participating. If interested, the principal investigator scheduled the interview.

Young adults recruited from the community. Nine young adults were recruited from the community using recruitment fliers, which were placed in Latino/a neighborhoods where young adults congregated. Participants in this group a) were ages 18-21; b) self-identified as Hispanic/Latina; c) spoke and read English; and d) self-identified as experiencing depressive symptoms during adolescence from a list of Diagnostic and Statistical Manual 5th Edition (DSM-V) MDD or Dysthymic disorder (DD) criteria on recruitment flyer. Fliers (in both English and Spanish) contained a description of DSM-V MDD or DD criteria in lay language and instructions to contact the principal investigator by phone, if interested in the study. Upon calling, the principal investigator explained the study, verified eligibility, and performed a distress screening to ensure that caller was not in acute distress (Appendix A; Draucker, Martsof, & Poole, 2009). If the screening was passed, an interview was scheduled.

Adolescents recruited from primary care services. Six adolescents were recruited from a primary care clinic serving a predominately Latino/a population. These participants a) were aged 13-17; b) self-identified as Hispanic/Latina; c) spoke and read English; and d) were identified by a primary care provider as having a clinical history of depression. The principal investigator

worked with health care providers at the clinic to identify potential participants on the schedule that day. While the potential participant was at the clinic, the provider introduced the adolescent and parents to the principal investigator if they were interested in hearing about the study. The principal investigator explained the study in detail, answered questions, obtained verbal parental consent and adolescent assent, and proceeded with an interview if the parent and adolescent agreed to participation. If they did not have time that day, the interview was arranged for a later date.

Young adults recruited from primary care services. Two young adults were recruited from the same primary care clinic. These participants a) were aged 18-21; b) self-identified as Hispanic/Latina; c) spoke and read English; d) were identified by a primary care provider as having a clinical history of depression; and e) reported experiencing depressive symptoms during adolescence. The principal investigator worked with providers at Pecar to identify potential participants. While they were at the clinic, the provider introduced the young adult to the principal investigator if the young adult was interested in the study. The principal investigator explained the study in detail, answered questions, obtained verbal informed consent, and proceeded with an interview if the young adult agreed to participation. If the participant did not have time that day, the interview was arranged for a later date.

Interview procedures. Interviews were conducted in English and audio-recorded, lasted approximately one hour, and took place in public locations with private rooms outside of the participants' homes but within their local

communities. Informed consent was obtained from young adult participants. Adolescent assent and parental permission were obtained for adolescent participants. After consent was obtained, the participant was given a brief demographic questionnaire to complete before the interview (Appendix B). Qualitative data was collected via semi-structured interviews driven by an interview guide (Appendix C).

Interviews began with broad questions regarding the participant's experience with her depressive symptoms and transitioned to more focused questions to clarify previous information discussed by the participant and ensure that other important information related to the study aims was collected. Since participants could have become distressed while recounting events related to their depressive symptoms, a distress protocol (Appendix D) was used in the case that the participant became acutely distressed or if safety issues arose during the interview (Draucker et al., 2009).

At the conclusion of the interview, the principal investigator and the participant worked together to construct a timeline that described how depressive symptoms, efforts to manage the depressive symptoms, and mental health treatment experiences, if any, unfolded over time. This timeline mapped out important events in the participants' depressive symptom trajectory in relation to their grade year in school, a common way that youth mark major events in their lives. The participant validated the chronology of the events on the timeline, providing an opportunity to clarify or add important details surrounding these

events. After completing the interview, the participant was given a \$30 gift card as compensation for her time and travel

Data management. Only the principal investigator and her student project team had access to participant information. Participant contact information left on the voicemail was transcribed and deleted. All participant information was de-identified and labeled with a study identification number. De-identified digital recordings were transcribed by a professional transcriptionist. The transcripts and audio recordings were stored in a HIPAA protected Box Health account according to Indiana University policy. Tables in Microsoft Word™ were used to organize the data analysis process.

Data Analysis and Interpretation

Participant narratives were analyzed according to two different qualitative data analysis approaches. Content analysis procedures as described by Miles, Huberman, and Saldana (2014) were used to determine the types of cultural stressors currently experienced by the Latina young women in the study (see Chapter 3). Grounded theory coding techniques as described by Charmaz (2014) were used to develop a grounded theory that explains how Latina adolescents experience, self-manage, and seek mental health services for depressive symptoms (see Chapter 4). These analysis strategies are described in detail in chapters 3 and 4.

Trustworthiness and credibility strategies. Charmaz (2005) outlines four strategies to enhance the credibility of grounded theory studies. Credibility describes the degree to which the framework is consistent with the data, and

originality refers to the freshness of the categories and their social and theoretical significance (Charmaz, 2005). To enhance these two strategies, the principal investigator met weekly with an expert on grounded theory methodology and periodically presented her emerging findings to the student project team members. The principal investigator also maintained an audit trail of memos describing the analytic decisions that were made during the coding process. Resonance describes how well the emerging categories are relevant to individuals who have experienced the phenomenon under study (Charmaz, 2005) and was enhanced by presenting emerging categories to subsequent participants and asking them about the relevance of these categories to their own experiences. Usefulness describes the practical utility of the framework (Charmaz, 2005). This was enhanced by receiving feedback on the final framework from the student project team members who frequently work with adolescents in community and mental health treatment settings.

Overview of Chapters 2-5

The overview of this dissertation project is outlined here. Chapters 2, 3, and 4 each describe findings of the dissertation research project (McCord, Draucker, & Bigatti, 2018). Chapter 2 is an integrative review of the literature examining the cultural stressors that are associated with depressive symptoms for Latino/a youth. Chapter 3 presents the results of a qualitative descriptive content analysis identifying the common cultural stressors that are experienced by contemporary Latina young women living in a tumultuous sociopolitical climate in the US. Chapter 4 is a description of a grounded theory framework that

describes how Latina adolescents experience, self-manage, and seek mental health services for their depressive symptoms. Chapter 5 is a synthesis of the findings of chapters 2, 3, and 4. Chapter 5 also contains a discussion of the study's connections to previous theory, the strengths and limitations of the study, and implications for research, clinical practice, and policy.

CHAPTER 2

Chapter 2 describes the results of an integrative review of the literature to determine which cultural stressors have been associated with depressive symptoms for Latino/a youth.

Introduction

The Latino/a population in the US nearly quintupled since the 1970s and now composes 17% of the US population (Pew Research Center, 2015). Latino/a youth currently compose 25% of all US children (CDC, 2014), and these youth suffer from significant health disparities, one of which is depressive symptoms (CDC, 2016). According to the Youth Risk Behavior Survey (CDC, 2016), 35.3% of Latino/a adolescents reported experiencing depressive symptoms in 2015, measured by the percentage of youth that felt so sad or hopeless in the last two weeks that they stopped taking part in some of their daily activities; in comparison, 28.6% of Caucasian adolescents and 33.9% of AA adolescents reported depressive symptoms. In Latino/a adolescents, depressive symptoms are associated with serious consequences, such as suicidality (CDC, 2016), substance use (Cano et al., 2015; Schwartz et al., 2015), and rule breaking behaviors (Cano et al., 2015). Due to the high prevalence and serious nature of this problem, attention to the mental health needs of Latino/a adolescents is urgent.

Recent immigration policies contributed to increased tension and negative attitudes towards the Latino/a population. Although immigrants to the US are often faced with discrimination, the process of acculturation for Latino/as has

become more turbulent in the last several years. The passage of Arizona Senate Bill 1070 in 2010, for example, enacted strict immigration policies directed towards the Latino/a population (American Immigration Council, 2011). This legislation received nationwide media attention and sparked similar bills in other states, further heightening anti-immigrant attitudes towards Latino/as across the US (Androff et al., 2011; Lyons, Coursey, & Kenworthy, 2013). These attitudes cast Latinos/as as being criminals, stealing American jobs, and burdening the US economy (Androff et al., 2011). Strict immigration policies and negative societal attitudes can increase the stress that immigrants experience and put them at risk for developing health problems (Bourhis et al., 1997).

Research on the relationship between culture and health outcomes in immigrant populations often takes two different perspectives. One field of research has examined how culture can serve as a protective factor against negative health outcomes for immigrant communities (Arrington, & Wilson, 2000). For example, Neblett, Rivas-Drake, and Umaña-Taylor (2012) found that having a strong bicultural identity is protective against depressive symptoms for Latino/a youth. Another area of research focuses on how culture can contribute to increased stress and risk of negative health outcomes for immigrants (Arrington, & Wilson, 2000). Studies guided by this perspective examine how problems such as discrimination can increase stress for immigrant youth and lead to negative mental health outcomes (Arrington, & Wilson, 2000). The current review focuses on research that explores how culture can precipitate stress for immigrant populations and lead to negative health outcomes.

Cultural stressors are negative events uniquely experienced by members of minority populations (Cano et al., 2015; Stein et al., 2012) and may be especially influential during adolescence, a stage in which identity development is a critical developmental task (Delgado et al., 2011). Many experts suggest that cultural stressors play a role in the development of depressive symptoms in Latino/a adolescents (Cano et al., 2015; Cervantes, Cardoso, & Goldbach, 2015; Stein et al., 2012). In research, these stressors have been referred to by several different terms, such as bicultural stressors (Piña-Watson, Dornhecker, & Salinas, 2015a; Schwartz et al., 2015), acculturative stressors (Forster et al., 2013), culturally-based stressors (Stein et al., 2012), and socio-cultural stressors (Lorenzo-Blanco et al., 2016b). However, the literature is saturated with inconsistencies in both conceptual and operational definitions of cultural stressors (Caplan, 2007).

Although the relationships between cultural stressors and depressive symptoms in Latino/a adolescents have been examined, no comprehensive review has been conducted to provide a cohesive picture of the specific cultural stressors that contribute to the development of depressive symptoms in Latino/a adolescents. Such a synthesis is important because it will help researchers and practitioners to better understand and address the high rate of depressive symptoms experienced by Latino/a adolescents. The purpose of this integrative review is to identify specific cultural stressors that are associated with the development of depressive symptoms in Latino/a adolescents.

Methods

Integrative reviews are conducted to systematically gather, synthesize, and analyze the literature on a specific phenomenon in order to examine the support for existing hypotheses, identify gaps in the literature, and uncover common methodological and theoretical issues (Ganong, 1987). This review was guided by Ganong's (1987) integrative review method. The steps of this method include formulating the research question, searching for relevant articles, recording the characteristics of the research, analyzing the findings, interpreting the results, and disseminating the findings.

Variables of Interest

Stress is the individual's perception of a threat or challenge when the demands of a situation outweigh an individual's resources, whereas a stressor is the situation that leads to the individual's perception of stress (Lazarus & Folkman, 1984). Universal stressors affect populations as a whole whereas cultural stressors are unique to members of minority ethnic groups (Stein et al., 2012). Cultural stressors can vary between minority groups as what one group perceives as stressful may not be present or perceived as stressful by a different group. This integrative review will draw from Lazarus and Folkman's (1984) definition of stress and Stein et al.'s (2012) description of cultural stressors. For this review, cultural stressors are defined as stressful negative events uniquely experienced by members of the Latino/a population living in the US.

The outcome variable of this review is the rate of depressive symptoms experienced by Latino/a adolescents. The DSM-V defines MDD as the

experience of depressed mood or loss of pleasure for a two-week period, at least four other depressive symptoms (weight gain/loss, insomnia/hypersomnia, fatigue, psychomotor agitation/retardation, feelings of worthlessness, inability to concentrate, or recurrent thoughts of death), and significant reduction in work or social functioning (American Psychiatric Association, 2013). When individuals experience at least two of these symptoms for two or more weeks, one of which must be depressed mood or loss of pleasure, they are classified as having depressive symptoms, even if they do not fully meet the criteria for a diagnosis of MDD (Rodríguez, Nuevo, Chatterji, & Ayuso-Mateos, 2012). Depressive symptoms, and not a clinical diagnosis of depression, is the outcome of interest for this review.

Search Strategy

The databases of PubMed, CINAHL, PsychINFO, and SocINDEX were used to search for peer-reviewed articles published between the years 2010 and 2017. The year 2010 was selected to coincide with the enactment of the Arizona Senate Bill 1070, with the assumption that cultural stressors for Latino/as living in the US likely intensified during this time. After consultation with a university librarian, the terms of “Latino/a,” “Adolescent,” “Depression,” and “Stress” were entered into the thesaurus of each database to determine the most appropriate indexed search terms to be used in each individual database. In addition to these thesaurus terms, “cultur*,” “bicultur*,” and “accultur*” were added to each database search. Three hundred and eighty-six articles were retrieved using this

search strategy. An additional seven articles were added to this total after ancestry searching.

Articles were included in the review if they (1) included Latino/a adolescent participants, (2) measured depressive symptoms, (3) measured at least one cultural stressor, and (4) determined the relationship between the cultural stressor and depressive symptoms. Articles were excluded from the analysis if the authors (1) included adults over 18 or children under 12 in the sample, (2) included pregnant or parenting adolescents, or (3) conducted the study outside the US.

Articles were considered to meet inclusion criterion 3 if they measured a variable that could be considered a negative, stressful event that is uniquely experienced by US Latinos/as. For instance, general family conflict was not considered a cultural stressor because it can be experienced by any adolescent regardless of ethnicity. Family culture conflict, however, was considered a cultural stressor because it involves conflict between a parent and child concerning differences in cultural values and preferences. Similarly, level of acculturation was not considered a cultural stressor since it is a process by which individuals balance the adoption of aspects of a new culture with maintaining aspects of their heritage culture (Rogers-Sirin, Ryce, & Sirin, 2014). However, acculturation can sometimes result in challenging and threatening situations, such as being separated from family members or facing discrimination in a new country, resulting in what is known as acculturative stress (Rogers et al., 2014).

For this reason, acculturative stress was considered a cultural stressor, while level of acculturation was not.

Data Collection

After removing 126 duplicates, the titles and abstracts of 267 articles were examined to determine if they met inclusion criteria. One hundred ninety-eight articles were eliminated after title and abstract screening, leaving 69 articles for full-text screening. Out of these 69 articles, 33 met the inclusion criteria and were included in this integrative review. A Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) diagram was used to record this process and reasons for article exclusion (Figure 2.1). Data from these 33 articles were then extracted and organized into an evidence table (Table 2.1) by the principal investigator. Two other student project team members reviewed the search procedures, examined the data tables, and confirmed the review conclusions.

Similar cultural stressors in the 33 articles were grouped into categories. The categories were labeled as follows: discrimination, family culture conflict, acculturative and bicultural stress, intragroup rejection, immigration stress, and context of reception. For each category, the principal investigator determined (a) how frequently the stressors in that category were discussed, (b) how the stressors were labeled, defined, and measured; and (c) how the stressors in each category were related to depressive symptoms. Based on the findings, recommendations are made for research, practice, and policy with this population.

Results

Seventeen of the 33 studies had a cross-sectional design, and 16 had a longitudinal design. Six different classifications of cultural stressors were identified in this review: Discrimination, family culture conflict, acculturative and bicultural stress, intragroup rejection, immigration stress, and context of reception. Table 2.2 provides a brief description of these classifications of cultural stressors.

Discrimination

Cultural stressors related to discrimination were examined in 26 out of 33 studies (79%). These stressors were labeled ethnic microaggressions (Huynh, 2012), anticipated discrimination (Paat, 2016), perceived ethnic discrimination (Cano et al., 2015; Davis et al., 2016; Huq, Stein, & Gonzalez, 2016; Park, Williams, Lijuan, & Alegría, 2017; Zeiders, Umaña-Taylor, & Derlan, 2013), perceived discrimination (Basáñez, Unger, Soto, Crano, & Baezconde-Garbanati, 2013; Chithambo, Huey, & Cespedes-Knadle, 2014; Gonzales-Backen, Bámaca-Colbert, Noah, & Rivera, 2017; Young, 2016), discrimination stress (Cervantes et al., 2015; Cervantes, Fisher, Córdova, & Napper, 2012; Piña-Watson et al., 2015a; Piña-Watson, Llamas, & Stevens, 2015b), societal discrimination (Behnke, Plunkett, Sands, & Bámaca-Colbert, 2011), and every day discrimination (Lorenzo-Blanco & Unger, 2015). Although these terms were defined differently, all the definitions suggested that discrimination for Latino/a adolescents involves “unfair, differential treatment” (Lorenzo-Blanco & Unger, 2015; Lorenzo-Blanco et al., 2011) based on ethnicity (Cano et al., 2015;

Schwartz et al., 2014; Zeiders et al., 2013), and includes negative behaviors from others such as derogatory remarks, prejudicial treatment, and violence (Schwartz et al., 2014).

Discrimination was measured with a variety of instruments, many of which had similar items. Some instruments measured sources of discrimination (Behnke et al., 2011; Gonzales-Backen et al., 2017; Lopez, LeBron, Graham, & Grogan-Kaylor, 2016; Stein et al., 2012; Zeiders et al., 2013), whereas others measured specific types of discriminatory behaviors (Cano et al., 2015; Davis et al., 2016; Cervantes et al., 2012; Cervantes et al., 2015), the frequency of discrimination (Basáñez et al., 2013; Chithambo et al., 2014; Lorenzo-Blanco & Unger, 2015; Lorenzo-Blanco et al., 2011), or the presence of discrimination (Lo, Hopson, Simpson, & Cheng, 2017). Three studies used instruments that assessed the adolescent's level of discomfort with experiences of discrimination (Huynh, 2012; Piña-Watson et al., 2015a; Piña-Watson et al., 2015b).

All studies that examined discrimination found significant relationships between discrimination and depressive symptoms. Societal discrimination (Behnke et al., 2011), anticipated discrimination (Paat, 2016), discrimination stress (Cervantes et al., 2012; Cervantes et al., 2015), perceived discrimination (Basáñez et al., 2013; Chithambo et al., 2014; Gonzales-Backen et al., 2017; Lorenzo-Blanco et al., 2011; Potochnick, Perreira, & Fuligni, 2012; Potochnick & Perreira, 2010; Young, 2016), ethnic discrimination from teachers and peers (Huq et al., 2016; Stein, Supple, Huq, Dunbar, & Prinstein, 2016), and ethnic microaggression frequency (Huynh, 2012) all had significant positive

associations with depressive symptoms in Latino/a adolescents. These studies thus provide strong evidence for a significant relationship between discrimination and depressive symptoms in Latino/a adolescents.

Family Culture Conflict

Cultural stressors related to family culture conflict were examined in 11 out of 33 studies (33%). These stressors were labeled parent-adolescent conflict (Bámaca-Colbert et al., 2012; Paat, 2016), culture conflict with parents (Behnke et al., 2011), intergenerational conflict (Li, 2014), parent-adolescent acculturation conflict (Huq et al., 2016), acculturation gap stress (Cervantes et al., 2015; Cervantes et al., 2012), family stress (Piña-Watson et al., 2015a; Piña-Watson et al., 2015b), mother-youth acculturation gap (Wiesner, Arbona, Capaldi, Kim, & Kaplan, 2015), and cultural value gap (Stein & Polo, 2014). The definitions provided for these stressors all highlighted disagreement with a family member related to a discrepancy between his or her cultural values and those of the adolescent (Behnke et al., 2011; Stein & Polo, 2014).

A variety of instruments were used to measure family culture conflict. Nine studies used instruments that assessed conflict with the adolescents' parents (Bámaca-Colbert et al., 2012; Behnke et al., 2011; Cervantes et al., 2015; Cervantes et al., 2012; Huq et al., 2016; Li, 2014; Paat, 2016; Stein & Polo, 2014; Wiesner et al., 2015), while two studies measured conflict with any family member (Piña-Watson et al., 2015a; Piña-Watson et al., 2015b). All eleven studies measured discrepancies in values relating to traditions (Behnke et al., 2011; Piña-Watson et al., 2015a), cultural norms (Cervantes et al., 2015;

Cervantes et al., 2012; Stein & Polo, 2014), or “different ways of doing things” (Li, 2014).

Ten studies found a significant relationship between family culture conflict and depressive symptoms. Parent adolescent conflict (Bámaca-Colbert et al., 2012), acculturation gap stress (Cervantes et al., 2015; Cervantes et al., 2012), parent adolescent acculturation conflict (Huq et al., 2016), cultural value gaps (Stein & Polo, 2014), intergenerational conflict (Li, 2014), mother-youth acculturation gaps (Wiesner et al., 2015), and family stress (Piña-Watson et al., 2015a; Piña-Watson et al., 2015b) were significantly and positively associated with depressive symptoms.

Additionally, the relationship between family culture conflict and depressive symptoms was moderated by gender in two studies. At low levels of family conflict, Piña-Watson et al. (2015a) found that girls had higher levels of depressive symptoms, but at high levels of family conflict, boys had greater depressive symptoms. Similarly, Behnke et al. (2011) discovered that culture conflict with father was directly and positively associated with depressive symptoms in boys, but the relationship between culture conflict with father and depressive symptoms was not significant for girls. Based on this evidence, it appears that family culture conflict is significantly associated with depressive symptoms in Latino/a adolescents, but family culture conflict may relate to the mental health of Latino boys and Latina girls in different ways.

Acculturative and Bicultural Stress

Cultural stressors related to acculturative stress and bicultural stress were examined in 6 out of 33 studies (18%). While both of these terms are commonly thought of as separate concepts with distinct definitions, they were often used interchangeably within the literature. Acculturative stress was commonly defined as the stress that results from acculturation, which is the process of changing values and practices as a result of coming in contact with another culture (Forster et al., 2013). Bicultural stress was consistently defined as the difficulties experienced when simultaneously navigating between one's heritage culture and a host culture (Cano et al., 2015). However, a few articles in this review addressing bicultural and acculturative stress used these terms interchangeably. Piña-Watson et al. (2015a) discussed the concept of bicultural stress but also referred to this concept as acculturative stress. Likewise, Stein et al. (2012) examined acculturative stress but used the Bicultural Stress Scale (BSS; Romero & Roberts, 2003) to operationalize this concept.

Three instruments were used to measure acculturative and bicultural stress. Forster et al. (2013) and Lorenzo-Blanco and Unger (2015) used items from the Acculturative Stress Scale (Gil, Wagner, & Vega, 2000), while Cano et al. (2015), Piña-Watson et al. (2015b), and Stein et al. (2012) used the Bicultural Stress Scale (Romero & Roberts, 2003). Additionally, Lorenzo-Blanco et al. (2016a) examined the association between reported parental acculturation stress and adolescent depressive symptoms, using a latent variable composed of scores from the Multidimensional Acculturative Stress Inventory (Rodriguez,

Myers, Mira, Flores, & Garcia-Hernandez, 2002), the Perceived Discrimination Scale (Whitbeck, Hoyt, McMorris, Chen, & Stubben, 2001), and Negative Context of Reception scale (Schwartz et al., 2014). Despite claiming to measure different concepts, all of these measures assess for similar stressors, including language stressors, discrimination, and family culture conflict. Additionally, several of the studies reported acculturative and bicultural stress as overall scores without reporting findings for the different subscales of the instruments (Cano et al., 2015, Forster et al. 2013; Lorenzo-Blanco et al., 2016a; Lorenzo-Blanco & Unger, 2015; Stein et al., 2012). All six studies found a significant positive association between acculturative or bicultural stress and depressive symptoms. Due to inconsistencies in how these stressors are defined and measured, however, it is difficult to draw conclusions about which specific elements of acculturative and bicultural stress contribute to depressive symptoms.

Intragroup Rejection

Cultural stressors related to intragroup rejection were examined in 4 out of 33 studies (12%). These stressors were labeled as intragroup rejection (Basáñez, Warren, Crano, & Unger, 2014), intra-ethnic discrimination (Lopez et al., 2016), and peer stress (Piña-Watson et al., 2015a; Piña-Watson et al., 2015b). While several authors did not define intragroup rejection, Basáñez et al. (2014) did define intragroup rejection as becoming the recipient of negative behaviors from another individual within the same ethnic group. Three instruments were used to measure intragroup rejection. To assess perceived pressures to “fit in” with Latino peers, Basáñez et al. (2014) used items from the

Multidimensional Acculturative Stress Inventory (Rodriguez et al., 2002), while Piña-Watson et al. (2015a, 2015b) used the Peer Subscale of the Bicultural Stress Scale (Romero & Roberts, 2003). Lopez et al. (2016) measured intra-ethnic discrimination with two questions assessing for discrimination experienced from other Latinos/as (Lopez et al., 2016). All four studies found a significant relationship between intragroup rejection and depressive symptoms (Basáñez et al., 2014; Lopez et al., 2016; Piña-Watson et al., 2015a; Piña-Watson et al., 2015b).

Immigration Stress

Cultural stressors related to immigration were examined in 3 out of 33 (9%) studies. None of these studies provided a definition of the stressors; however, commonalities in the measures of immigration stress suggest that it is characterized by the specific challenges surrounding the event of immigrating to a new country. In two studies, one instrument was used to assess for immigration stress by asking participants about the difficulties they faced when leaving their home country (Cervantes et al., 2015; Cervantes et al., 2012). Another study examined the overall migration experience by assessing the number of years the adolescent was separated from their primary caregiver, the presence of a stressful migration event, and the adolescent's involvement and satisfaction with the decision to move to the US (Potochnick & Perreira, 2010). Each of these studies found a significant positive relationship between immigration stress and depressive symptoms in Latino/a adolescents. The strength of these findings,

however, is limited by the lack of a common definition and measurement of immigration stress.

Context of Reception

Cultural stressors related to context of reception were examined in 2 of the 33 (6%) studies. The context of reception was consistently defined as “the opportunity structure, degree of openness versus hostility, and acceptance in the local community” (Schwartz et al., 2014, p. 2). One study measured context of reception using an instrument that assessed the perception of the degree to which the societal opportunity structure did not favor one's ethnic group (Cano et al., 2015). Another study used an instrument measuring the degree to which individuals felt thwarted in their attempts to integrate into the receiving community (Schwartz et al., 2014). Both of these studies revealed that a perceived negative context of reception was positively associated with depressive symptoms in Latino/a adolescents (Cano et al., 2015; Schwartz et al., 2014).

Discussion

All of the studies in this review found a significant relationship between a cultural stressor and depressive symptoms in Latino/a adolescents. However, the strength of these findings differed based on the category of the stressors. Discrimination and family culture conflict were the two most widely researched cultural stressors, and strong evidence exists for the association between these stressors and depressive symptoms in Latino/a adolescents. Acculturative and bicultural stressors were also associated with depressive symptoms in several

studies. Although intragroup rejection, immigration stress, and context of reception were also associated with depressive symptoms in Latino/a adolescents, fewer studies examined these stressors and thus the evidence supporting their relationship with depressive symptoms is not as robust. More research on intragroup rejection, immigration stress, and context of reception is needed before strong conclusions can be drawn about the relationship between these concepts and depressive symptoms in Latino/a adolescents.

Limitations

The findings of this review should be understood in the context of the limitations of the literature examined. Most notably, some conclusions were tempered due to inconsistent definitions provided for the cultural stressors and the variability of the instruments used to measure them. Acculturative and bicultural stress, for example, were associated with depressive symptoms, but it was difficult to draw conclusions about what specific aspects of such stress can be implicated in Latino/a adolescent depression due to the vague and sometimes conflicting definitions of these constructs. Despite these limitations, these findings do have research, clinical, and policy implications.

Research Implications

While there were some commonalities in how cultural stressors were conceptualized, the studies varied in how the stressors were defined and measured. One of the main tasks for theorists and researchers seeking to understand the relationship between cultural stressors and depressive symptoms in this population is to develop consistent definitions and use common

instruments to measure cultural stressors such as discrimination, family culture conflict, acculturative stress and bicultural stress, intragroup rejection, and immigration stress. Researchers can then compare findings across studies and have more confidence in the evidence generated by the cumulative findings of these studies.

Moving forward, researchers will need to explore cultural stressors that are related to present-day concerns in the Latino/a community. Most studies in this review examined cultural stressors based on foundational research from the early 2000s. For instance, several of the studies used data from the Children of Immigrants Study, a longitudinal study conducted in San Diego and Miami from 1999-2006 (Portes & Rubén, 2012) and Project RED (Reteniendo y Entendiendo Diversidad para Salud), a longitudinal study conducted in Los Angeles from 2005-2007 (Unger, Ritt-Olson, Wagner, Soto, & Baezconde-Garbanati, 2009). Although stressors experienced by Latino/a adolescents during the early 2000s are likely still relevant today, there may be others that surfaced in more recent years that have not been addressed. The widespread use of the Internet in this age group, new avenues for immigration, and the current political climate may lead to different types of cultural stress for contemporary Latino/a adolescents. For example, one cultural stressor that was not captured in this review is the fear of deportation and a sense of hopelessness that accompanies it (Androff et al., 2011; Salas, Ayón, & Gurrara, 2013). Future research should also address how resiliency factors, such as a strong bicultural ethnic identity, can protect against depressive symptoms for Latino/a youth facing the cultural stressors identified in

this review. While the stressors identified in this review may be unique to Latino/a adolescents in many cases, researchers should examine how these cultural stressors may be impacting the mental health of other groups of ethnic minority and immigrant adolescents.

Clinical Implications

The findings of this review have important implications for practitioners who work with Latino/a adolescents experiencing depressive symptoms. Because evidence suggests that a number of cultural stressors are associated with depression in this group, practitioners should initiate conversations about how these stressors are experienced in the day-to-day lives of the adolescents. Clinicians might then inquire about how adolescents cope with these stressors and explore coping strategies that might mitigate the negative consequences of the stressors.

While the etiology of depression in any group is complex and multifaceted, this review provides evidence that discrimination in particular is strongly associated with depressive symptoms in Latino/a adolescents. Healthcare providers therefore should address this issue in their therapeutic work with this group. For example, Latino/a adolescents may benefit from an opportunity to discuss any ethnically based microaggressions, derogatory remarks, and violence they have experienced, within the safety of a therapeutic relationship. Moreover, because studies have noted that a strong sense of ethnic identity can buffer against the effects of discrimination (Huq et al., 2016), mental health providers might facilitate ethnic identity exploration in Latino/a adolescents and

help them challenge any negative internalized beliefs they hold about themselves as a result of discrimination (Graham, Sorenson, & Hayes-Skelton, 2013; Quintana, 2007).

The review also found that family culture conflict is strongly associated with depressive symptoms in Latino/a adolescents. This finding suggests that culturally relevant family therapy approaches in which Latino/a adolescents and their parents can discuss conflicts related to disparate cultural values would likely be useful. Parents are typically involved in the mental health treatments that their adolescents receive, but for Latino/a youth this may be even more important because their culture often emphasizes the value of *familismo*, or family closeness (Andrés-Hyman, Ortiz, Añez, Paris, & Davidson, 2006). Practitioners can help Latino/a parents and adolescents explore their conflict through the perspective of culture and acculturation, allowing parents and adolescents to gain new insight into their family interactions (Stein & Polo, 2014).

Public Policy Implications

While therapeutic interventions can be implemented on the individual level to help Latino/a adolescents cope with cultural stressors, action also needs to be taken at local, state, and national policy levels to endorse programs that can minimize their exposure to discrimination, immigration stressors, and negative context of reception. Immigration policy and national dialogue surrounding immigration in the US will affect how Latino/a adolescents experience discrimination, immigration stressors, and context of reception. For example, programs that seek to promote unity and racial/ethnic integration in schools and

communities are needed to decrease perceived discrimination and intragroup rejection for Latino/a youth (Seaton & Douglass, 2014). According to professional codes of conduct (American Counseling Association, 2014; American Nurses Association, 2010; American Psychological Association, 2001; National Association of Social Workers, 2008), all mental health disciplines have a responsibility to advocate for patients who are subject to social injustices that impede their mental health. Practitioners thus are called upon to advocate for public policies that promote the mental health of Latina/o adolescents by ensuring acceptance and integration of Latino/a families in their local communities.

Conclusion

Latino/a adolescents face cultural stressors above and beyond those stressors experienced by all adolescents living in the US, and this has contributed to a high rate of depressive symptoms in this population. Discrimination, family culture conflict, acculturative and bicultural stress, immigration stress, intragroup rejection, and context of reception emerged as cultural stressors that are associated with depressive symptoms in this population. Practitioners can use this information to improve clinical practices and advocate for policy changes that will ultimately decrease the number of Latino/a adolescents who suffer from depressive symptoms. Future research should determine what contemporary cultural stressors impact the mental health of Latino/a youth.

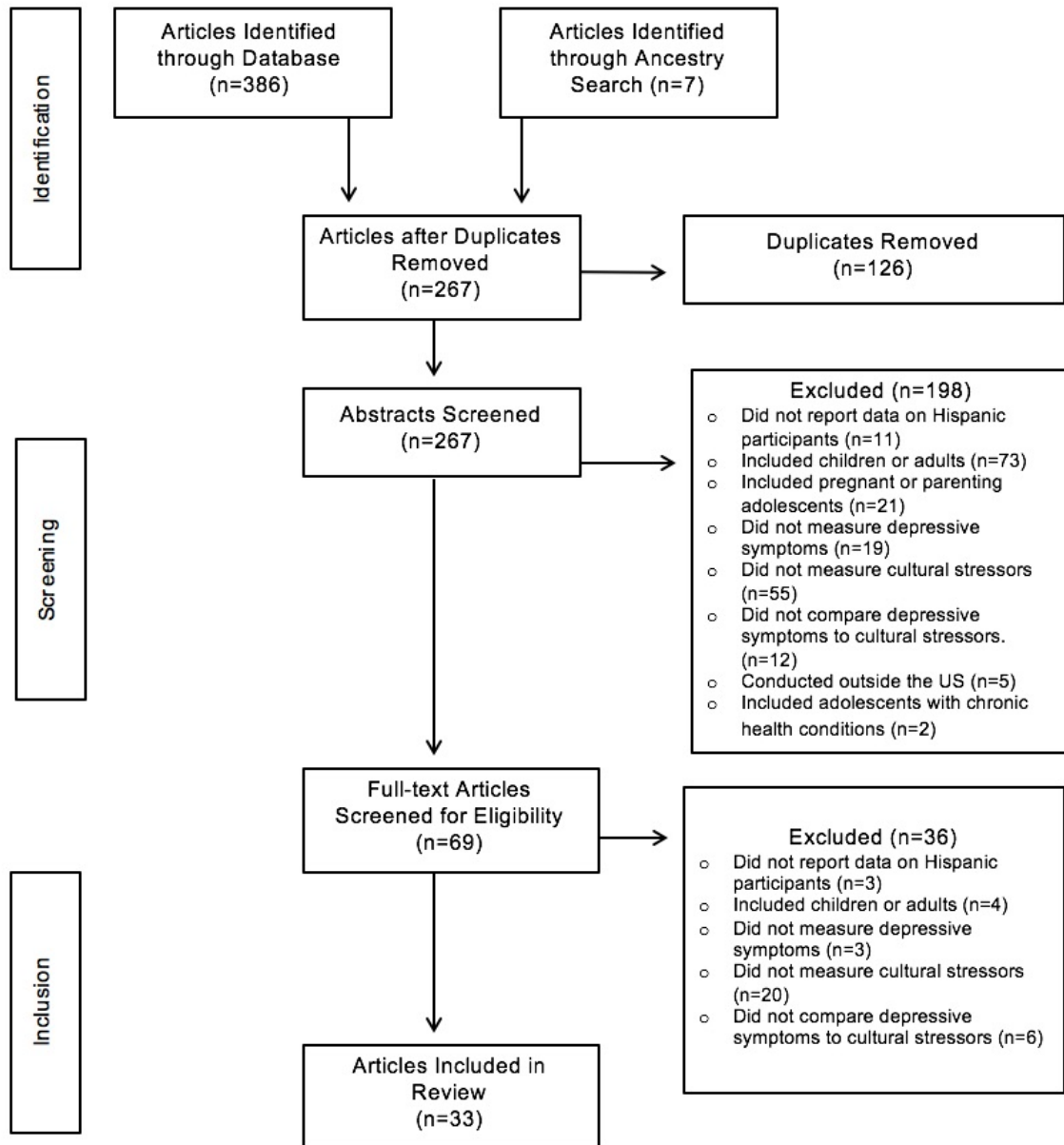


Figure 2.1. This PRISMA diagram illustrates the search strategy employed in this integrative review (Modified from Moher, Liberati, Tetzlaff, Altman, & the PRISMA Group, 2009)

Table 2.1

Integrative Review Evidence Table

Source	Sample	Methods	Cultural Stressor	Findings
Bámaca et al. (2012)	N=271 <u>Mean Age:</u> 12 <u>Female:</u> 100% <u>Mexico:</u> 100% <u>US born:</u> 60%	<u>Design:</u> Cross Sectional Survey <u>Setting:</u> 10 Southwestern US Schools	Family Culture Conflict: <u>Definition:</u> Parent-adolescent conflict was not defined. <u>Measure:</u> 15-item Likert scale asking respondents about general family conflict with a few items specifically related to Mexican American values.	There was an association between parent-adolescent conflict and adolescent depressive symptoms for both early (r=0.47; p<0.001) and middle adolescents (r=0.29; p<0.001).
Basáñez et al. (2013)	N= 1045 <u>Mean Age:</u> NA <u>Female:</u> 54% <u>Mexico:</u> 86% <u>US born:</u> 89%	<u>Design:</u> Longitudinal Survey <u>Setting:</u> 7 LA High Schools	Discrimination: <u>Definition:</u> Discrimination is “a negative action towards a social group or its members on account of group membership” (p. 245). <u>Measure:</u> 10-item scale asking respondents to specify how often they feel they are treated poorly because of their ethnic or cultural background (Guyll, Matthews, & Bromberger, 2001)	Perceiving discrimination in 9th grade was associated with depressive symptoms in 11th grade ($\beta=0.23$, p<0.01).
Basáñez et al. (2014)	N= 2214 <u>Mean Age:</u> 15 <u>Female:</u> 54% <u>Mexico:</u> 84% <u>US born:</u> 85%	<u>Design:</u> Longitudinal Survey <u>Setting:</u> 7 LA High Schools	Intragroup Rejection: <u>Definition:</u> Intragroup Rejection is “negative behaviors originating from Latino/as against other Latino/as” (p. 2). <u>Measure:</u> Multidimensional Acculturative Stress Inventory (Rodriguez et al., 2002)- 4 items from the Pressure against Acculturation subscale	Intragroup Rejection from Latino/as in 10 th grade was associated with depressive symptoms in 11 th grade ($\beta=0.14$; p<0.001).

Behnke et al. (2011)	<p>N= 383 <u>Mean age:</u> 14.6 <u>Female:</u> 53% <u>Mexico:</u> 69% <u>US born:</u> 84%</p>	<p><u>Design:</u> Cross-Sectional Survey</p> <p><u>Setting:</u> 1 LA High School</p>	<p>Discrimination: <u>Definition:</u> Societal Discrimination was defined as “unfair treatment based on race, culture, and/or ethnicity from various groups in society” (p. 1182). <u>Measure:</u> 10-item scale asking how often teens were affected by discrimination from various individuals (Whitbeck et al., 2001)</p> <p>Family Culture Conflict: <u>Definition:</u> Culture conflict with parents was defined as “intense arguments with parents over cultural values” (p. 1182). <u>Measure:</u> Parent-Adolescent Conflict Scale (Smetana, 1988)-Items asking adolescents to report how intense the disagreements with their mothers and fathers were regarding cultural traditions.</p>	<ul style="list-style-type: none"> · Societal discrimination was associated with depressive symptoms for girls ($r=0.3$; $p<0.05$) and boys ($r=0.24$; $p<0.05$). · Culture conflict with father associated with depressive symptoms in boys ($r=0.21$; $p<0.05$) and girls ($r=0.25$; $p<0.05$). · Culture conflict with mother associated with depressive symptoms in boys ($r=0.27$; $p<0.05$) and girls ($r=0.15$; $p<0.05$).
Cano et al. (2015)	<p>N= 302 <u>Mean age:</u> 14.5 <u>Female:</u> 47% <u>Nationality:</u> <i>Miami:</i> Cuba: 61% <i>LA:</i> Mexico: 70% <u>Nativity:</u> US born: 0%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> Mental health treatment and schools in LA, Miami, El Paso, and Lawrence</p>	<p>Discrimination: <u>Definition:</u> Perceived Ethnic Discrimination defined as “negative attitudes, beliefs, and differential treatment toward members of minority ethnic groups” (p.32). <u>Measure:</u> 7-item scale assessing being called names, followed around stores, and viewed with suspicion (Phinney, Madden, & Santos, 1998)</p>	<ul style="list-style-type: none"> · Perceived ethnic discrimination ($r=0.3$; $p<0.01$), context of reception ($r=0.25$; $p<0.01$), and bicultural stress ($r=0.45$; $p<0.01$) were significantly associated with depressive symptoms.

			<p>Context of Reception: <u>Definition:</u> Perceived context of reception is “the perception that the host culture is unwelcoming and hostile” (p. 32). <u>Measure:</u> 6-item scale assessing the perception of the degree to which the opportunity structure of society does not favor one's ethnic group</p> <p>Bicultural Stress: <u>Definition:</u> Bicultural stress was defined as “perceived pressures emanating from interactions with both the heritage and receiving cultural communities” (p. 32). <u>Measure:</u> Bicultural Stress Scale (BSS; Romero & Roberts, 2003)</p>	
Cervantes et al. (2015)	<p>N= 1187 <u>Mean age:</u> 14.9 <u>Female:</u> 45% <u>Nationality:</u> Mexico: 47% <u>Nativity:</u> US born: 84%</p>	<p><u>Design:</u> Two-group Cross Sectional Survey</p> <p><u>Setting:</u> LA, Miami, El Paso, and Lawrence</p>	<p>Discrimination: <u>Definition:</u> Discrimination stress was not defined. <u>Measure:</u> The Hispanic Stress Inventory-Adolescent Version (HSI-AV; Cervantes et al., 2012)- Discrimination Stress Subscale</p> <p>Family Culture Conflict: <u>Definition:</u> Acculturation gap stress was not defined. <u>Measure:</u> HSI-AV (Cervantes et al., 2012)- Acculturation Gap Subscale</p> <p>Immigration Stress: <u>Definition:</u> Immigration stress was not defined. <u>Measure:</u> HSI-AV (Cervantes et al., 2012)- Immigration Stress Subscale</p>	<p>Discrimination stress ($\beta=1$; $p<0.001$), acculturation gap stress ($\beta=0.48$; $p<0.001$), and immigration stress ($\beta=0.34$; $p<0.001$), were associated with depressive symptoms.</p>

Cervantes et al. (2012)	<p>N= 992</p> <p><u>Mean Age:</u> 14.8</p> <p><u>Female:</u> 56%</p> <p><u>Mexico:</u> 47%</p> <p><u>US born:</u> 85%</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> LA, Miami, El Paso, and Boston</p>	<p>Discrimination:</p> <p><u>Definition:</u> Discrimination stress was not defined.</p> <p><u>Measure:</u> The Hispanic Stress Inventory-Adolescent Version (Cervantes et al., 2012)-Discrimination Stress Subscale</p> <p>Family Culture Conflict:</p> <p><u>Definition:</u> Acculturation gap stress was not defined.</p> <p><u>Measure:</u> The Hispanic Stress Inventory-Adolescent Version (Cervantes et al., 2012)-Acculturation Gap Subscale</p> <p>Immigration Stress:</p> <p><u>Definition:</u> Immigration stress was not defined.</p> <p><u>Measure:</u> The Hispanic Stress Inventory-Adolescent Version (Cervantes et al., 2012)-Immigration Stress Subscale</p>	<p>Discrimination stress ($r=0.36$; $p<0.001$), acculturation gap stress ($r=0.4$; $p<0.001$), and immigration stress ($r=0.15$; $p<0.001$) were associated with depressive symptoms.</p>
Chithambo et al. (2014)	<p>N= 395</p> <p><u>Mean age:</u> 15.3</p> <p><u>Female:</u> 51%</p> <p><u>Mexico:</u> 48%</p> <p><u>US born:</u> 78%</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> 1 LA High School</p>	<p>Discrimination:</p> <p><u>Definition:</u> Perceived discrimination defined as “a process by which dominant groups attempt to maintain their status within the social hierarchy” (p. 54).</p> <p><u>Measure:</u> Everyday Discrimination Scale (Essed, 1991)</p>	<p>Perceived discrimination was associated with depression ($r=0.44$; $p<0.05$).</p>

Davis et al. (2016)	<p>N= 302 <u>Mean age:</u> 14.5 <u>Female:</u> 47% <i>Miami</i> <u>Cuba:</u> 61% <i>LA</i> <u>Mexico:</u> 70% <u>US born:</u> 0%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> 13 LA Schools; 10 Miami schools</p>	<p>Discrimination: <u>Definition:</u> Perceived ethnic discrimination occurs “when an individual believes that s/he has experienced unfair treatment by others based on her/his ethnic background” (p. 458). <u>Measure:</u> 7-item scale referring to being called names, followed around stores, and viewed with suspicion (Phinney et al., 1998).</p>	<p>Discrimination was associated with depressive symptoms at all three time points (T1: $r=0.3$; $p<0.001$; T2: $r=0.29$; $p<0.001$; T3: $r=0.23$; $p<0.001$).</p>
Delgado et al. (2011)	<p>N= 246 <u>Mean age:</u> 14.25 <u>Female:</u> 50% <u>Mexico:</u> 100% <u>US born:</u> 0%</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> Southeast US</p>	<p>Discrimination: <u>Definition:</u> Perceived discrimination was not defined. <u>Measure:</u> 4 items from the Adolescents’ Experiences with Racism Scale to assess discrimination from peers in school</p>	<p>Discrimination was associated with depressive symptoms for younger ($r=0.41$; $p<0.001$) and older adolescents ($r=0.32$; $p<0.001$).</p>
Forster et al. (2013)	<p>N= 1167 <u>Mean age:</u> 14 <u>Female:</u> 54% <u>Mexico:</u> 84% <u>US born:</u> 89%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> 7 LA Schools</p>	<p>Acculturative Stress: <u>Definition:</u> “Stress that occurs as a result of the acculturation process” (p. 2). <u>Measure:</u> Modified version of the Acculturative Stress Scale (Gil et al., 2000)</p>	<p>Acculturative stress in 9th grade associated with depressive symptoms in 10th grade ($\beta=0.11$, $p<0.001$).</p>
Gonzales-Baken (2017)	<p>N=338 <u>Mean age:</u> 7th grd: 12.3 10th grd: 15.2 <u>Female:</u> 100% <u>Mexico:</u> 100% <u>US Born:</u> 7th grd: 64% 10th grd: 61%</p>	<p><u>Design:</u> Cross sectional survey</p> <p><u>Setting:</u> 4 schools in Southwest US</p>	<p>Discrimination <u>Definition:</u> Perceived discrimination was not defined. <u>Measure:</u> Perceived Discrimination Scale (Whitbeck et al., 2001)</p>	<p>Perceived discrimination was associated with depressive symptoms ($r=0.38$, $p<0.001$).</p>

Huq et al. (2016)	<p>N= 172 <u>Mean age:</u> 14 <u>Female:</u> 53% <u>Mexico:</u> 78% <u>US Born:</u> NA</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> 2 middle and 1 high school in Southeastern State</p>	<p>Discrimination: <u>Definition:</u> Racial/Ethnic Discrimination was not conceptually defined. <u>Measure:</u> Adult and Peer Discrimination Scale (Way, 1997)</p> <p>Family Culture Conflict: <u>Definition:</u> Parent-adolescent acculturation conflict is defined as “conflict that explicitly relates to differences in cultural values between parents and their children due to differential acculturation” (p. 1). <u>Measure:</u> 4 items from the BSS (Romero & Roberts, 2003)</p>	<p>Acculturation conflict (r=0.25, p<0.01) and discrimination (r=0.24, p<0.01) were associated with depressive symptoms.</p>
Huynh (2012)	<p>N= 360 <u>Mean age:</u> 17 <u>Female:</u> 57% <u>Mexico:</u> 95% <u>US Born:</u> NA</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> 2 LA High Schools</p>	<p>Discrimination: <u>Definition:</u> Ethnic microaggressions are ‘brief and commonplace daily verbal, behavioral, and environmental indignities, whether intentional or unintentional, that communicate hostile, derogatory, or negative racial slights and insults to the target person or group’ (p. 831). <u>Measure:</u> Ethnic Microaggressions Scale (Huynh, 2012)</p>	<p>Frequency of microaggressions was associated with depressive symptoms (r=0.24, p<0.001).</p>
Li, Y. (2014)	<p>N= 2676 <u>Mean age:</u> 14.2 <u>Female:</u> 51% <u>Cuba:</u> 41% <u>Mexico:</u> 25% <u>US born:</u> 57%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> Miami, San Diego</p>	<p>Family Culture Conflict: <u>Definition:</u> Intergenerational conflict is “a result of adolescents’ new perceptions of autonomy, family rules, and parental authority as they enter puberty” (p. 81). <u>Measure:</u> The Intergenerational Conflict Scale (Portes & Rumbaut, 2001)</p>	<p>Intergenerational conflict was associated with depressive symptoms ($\beta=0.44$, p<0.001).</p>

Lo et al. (2017)	<p>N= 2185 <u>Mean age:</u> 14.1 <u>Female:</u> 57% <u>Nationality:</u>NA <u>US Born:</u> NA</p>	<p><u>Design:</u> Longitudinal survey</p> <p><u>Setting:</u> Miami, San Diego</p>	<p>Discrimination: <u>Definition:</u> Discrimination was not defined. <u>Measure:</u> One item assessing the presence or absence of discrimination, and one item assessing the belief that racial/ethnic discrimination would continue despite level of education obtained</p>	<p>Perceived discrimination in education at time 2 was associated with depression at time 2 (b=0.394, p<0.01).</p>
Lopez et al. (2016)	<p>N= 2931 <u>Mean age:</u> 14.2 <u>Female:</u> 50% <u>Nationality:</u> Cuba: 41% Mexico: 25% <u>Nativity:</u> US born: 53%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> Miami, San Diego</p>	<p>Discrimination: <u>Definition:</u> Discrimination was not defined. <u>Measure:</u> Two questions asking “Have you ever felt discriminated against?” (y/n) and “By whom?” (teachers, students, counselors, White Americans in general)</p> <p>Intragroup Rejection: <u>Definition:</u> Intra or Co-ethnic Discrimination is defined as “discrimination from one’s own racial or ethnic minority group” (p. 132). <u>Measure:</u> Two questions asking “Have you ever felt discriminated against?” (y/n) and “By whom?” (Cubans or Latinos in general)</p>	<p>Discrimination from teachers ($\beta=0.06$, $p<0.05$), students ($\beta=0.05$, $p<0.05$), Cubans ($\beta=0.19$, $p<0.001$), and Latinas/os ($\beta=0.19$, $p<0.001$) were positively associated with depressive symptoms.</p>
Lorenzo-Blanco et al. (2015)	<p>N= 1919 <u>Mean age=</u> 14 <u>Female=</u> 52% <u>Nationality:</u> Mexico: 84% <u>Nativity:</u> US born: 87%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> 7 LA High Schools</p>	<p>Discrimination: <u>Definition:</u> Everyday Discrimination is “perceived daily experiences of unfair, differential treatment” (p. 1985). <u>Measure:</u> 10-item scale assessing frequency of perceived experiences with everyday discrimination (Guyll et al., 2001)</p>	<p>Discrimination at T1 associated with depressive symptoms at T1 ($r=0.34$, $p<0.001$) and T3 ($r=0.16$, $p<0.001$). Acculturative stress at T1 associated with depressive symptoms at T1</p>

			<p>Acculturative Stress: <u>Definition:</u> Acculturative Stress is “stress that results from the acculturation process” (p. 1986). <u>Measure:</u> 3-item scale about frequency with experiences with acculturative stress (Gil et al., 2000)</p>	(r=0.25, p<0.001) and 3 (r=0.13, p<0.001).
Lorenzo-Blanco et al. (2011)	<p>N= 1124 <u>Mean age:</u> 14 <u>Female:</u> 54% <u>Nationality:</u> Mexico: 86% <u>Nativity:</u> US born: 86%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> 7 LA High Schools</p>	<p>Discrimination: <u>Definition:</u> Perceived Discrimination is “perceived daily experiences of unfair, differential treatment” (p. 3) <u>Measure:</u> Ten item scale assessing frequency of perceived experiences with ethnic discrimination (Guyl et al., 2001)</p>	Perceived discrimination was associated with depressive symptoms (r=0.22, p<0.001).
Lorenzo-Blanco et al. (2016a)	<p>N= 293 <u>Mean age:</u> 14.5 <u>Female:</u> 47% <i>Miami</i> <u>Cuba:</u> 61% <u>DR:</u> 8% <i>LA</i> <u>Mexico:</u> 70% <u>El Salvador:</u> 9% <u>Nativity:</u> NA</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> Miami, Los Angeles</p>	<p>Acculturative Stress <u>Definition:</u> Parental Acculturation Stress was defined as a construct consisting of perceived discrimination, experiencing a negative context of reception, and acculturative stress. <u>Measure:</u> Latent variable was developed from scores on the Perceived Discrimination Scale, Negative Context of Reception Items (Schwartz et al., 2014), and Multidimensional Acculturative Stress Inventory (Rodriguez et al., 2002)</p>	Increases in parental acculturative stress overtime were associated with higher adolescent depressive symptoms ($\beta=0.045$, p<0.5).

Paat et al. (2016)	<p>N= 775 <u>Mean age:</u> 14 <u>Male:</u> 52% <u>Mexico:</u> 100% <u>US born:</u> 57%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> San Diego and Miami</p>	<p>Discrimination <u>Definition:</u> Anticipated discrimination is not conceptually defined. <u>Measure:</u> One item asking participants if they believed that they would continue to be discriminated regardless of level of education</p> <p>Family Culture Conflict <u>Definition:</u> Parent-child conflict is defined as discrepancies in the way of handling things between the participants and their parents. <u>Measure:</u> Two items asking how often adolescent and parents preferred the American ways of doing things. Difference between perceived parental response from participants response.</p>	<p>Anticipated discrimination was associated with depressive tendencies ($\beta=0.104$, $p<0.01$), but parent-child conflict was not.</p>
Park et al. (2017)	<p>N=269 <u>Mean age:</u> 14.1 <u>Female:</u> 57% <u>Mexico:</u> 100% <u>US Born:</u> 71%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> Midwest</p>	<p>Discrimination <u>Definition:</u> Perceived racial/ethnic discrimination is defined as unfair treatment from others on the basis of one's race or ethnicity. <u>Measure:</u> Perceptions of Racism in Children and Adolescents Scale (Pachter, Szalacha, Bernstein, & García Coll, 2010)</p>	<p>Discrimination and depressive symptoms associated at all time points (T1: $r=0.33$, $p<0.001$; T2: $r=0.39$, $P<0.001$; T3: $r=0.39$, $p<0.001$)</p>
Piña-Watson et al. (2015a)	<p>N= 516 <u>Mean age:</u> 16.2 <u>Female:</u> 53% <u>Mexico:</u> 100% <u>US born:</u> 92%</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> 1 high school in South Texas</p>	<p>Family Culture Conflict: <u>Definition:</u> Family stress was not defined. <u>Measure:</u> BSS (Romero & Roberts, 2003) Family Stress Subscale</p> <p>Discrimination: <u>Definition:</u> Discrimination stress was not defined. <u>Measure:</u> BSS (Romero & Roberts, 2003) Discrimination Subscale</p>	<p>Family stress ($r=0.45$, $p<0.001$), discrimination ($r=0.36$, $p<0.001$), and peer stress ($r=-0.33$, $p<0.001$) were associated with depressive symptoms.</p>

			<p>Intragroup Rejection: <u>Definition:</u> Peer stress was not defined. <u>Measure:</u> BSS (Romero & Roberts, 2003) Peer Stress Subscale</p>	
Piña-Watson (2015b)	<p>N= 524 <u>Mean age:</u> 16 <u>Female:</u> 53% <u>Nationality:</u> <u>Mexico:</u> 100% <u>US born:</u> 91%</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> 1 high school in South Texas</p>	<p>Bicultural Stress: <u>Definition:</u> “Bicultural stress is that which results from difficulties navigating <i>both</i> the majority cultural and culture of origin.” (p. 671). <u>Measure:</u> BSS (Romero & Roberts, 2003)</p> <p>Family Culture Conflict: <u>Definition:</u> Family stress was not defined. <u>Measure:</u> BSS (Romero & Roberts, 2003) Family Stress Subscale</p> <p>Discrimination: <u>Definition:</u> Discrimination stress was not defined. <u>Measure:</u> BSS (Romero & Roberts, 2003) Discrimination Subscale</p> <p>Intragroup Rejection: <u>Definition:</u> Peer stress was not defined. <u>Measure:</u> BSS (Romero & Roberts, 2003) Peer Stress Subscale</p>	<p>Family stress ($r=0.438$, $p<0.01$), discrimination ($r=0.33$, $p<0.01$), and peer stress ($r=0.31$, $p<0.01$) were associated with depressive symptoms. Total bicultural stress was associated with depression ($\beta=0.467$, $p<0.001$).</p>
Potochnick et al. (2012)	<p>N= 463 <u>Mean age:</u> 15 <u>Female:</u> 50-56% <u>Mexico:</u> 46%-74% <u>US born:</u> 26-83%</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> High schools in NC and LA</p>	<p>Discrimination: <u>Definition:</u> Perceived discrimination was not defined. <u>Measure:</u> Perceived discrimination was measured based on the likelihood of experiencing four hypothetical situations of mistreatment due to race and a daily diary checklist of experiences of discrimination.</p>	<p>Perceived discrimination was associated with daily depressive symptoms ($b=0.06$, $p<0.01$).</p>

<p>Potochnick et al. (2010)</p>	<p>N= 255 <u>Mean age:</u> 13.9 <u>Female:</u> 56% <u>Mexico:</u> 70% <u>US born:</u> 0%</p>	<p><u>Design:</u> Cross Sectional Survey</p> <p><u>Setting:</u> 25 North Carolina High Schools and Middle Schools</p>	<p>Discrimination: <u>Definition:</u> Discrimination was not defined. <u>Measure:</u> Four items from the Youth Adaptation and Growth Questionnaire (Portes & Rumbaut, 2001)</p> <p>Immigration Stress: <u>Definition:</u> Migration stress was not defined. <u>Measure:</u> Number of years adolescent was separated from caregiver, presence of a stressful migration event, and involvement and satisfaction with decision to move to US</p>	<p>Dissatisfaction with migration (AOR 1.67; 95%CI 1.03–2.69), not having US documentation (AOR 7.89; 95%CI 1.33–46.79), and discrimination (AOR 55.09; 95%CI 2.10–1448.0) associated with depression.</p>
<p>Schwartz et al. (2014)</p>	<p>N= 302 <u>Mean age:</u> 14.5 <u>Female:</u> 47% <u>Miami:</u> <u>Cuba:</u> 61% <u>LA:</u> <u>Mexico:</u> 70% <u>US born:</u> 0%</p>	<p><u>Design:</u> Longitudinal Survey</p> <p><u>Setting:</u> Miami and Los Angeles</p>	<p>Discrimination: <u>Definition:</u> Discrimination was defined as “micro-aggressions, specific acts of prejudice, exclusion, denigration, or violence and to generally unwelcoming climate directed toward individuals because of their racial or ethnic group” (p. 2). <u>Measure:</u> Seven items asking about the degree to which participants were treated unfairly by members of the receiving community</p> <p>Context of Reception: <u>Definition:</u> Context of reception is “the opportunity structure, degree of openness versus hostility, and acceptance in the local community” (p. 2). <u>Measure:</u> Nine items reflecting the possibility of achieving the American Dream and the feeling of being blocked or thwarted in one’s attempts to integrate oneself into the receiving community and society.</p>	<p>Perceived discrimination in Miami ($r=0.04$, $p<0.05$) and LA ($r=0.3$, $p<0.01$) samples was associated with depressive symptoms. Negative context of reception was also associated with depressive symptoms in Miami ($r=0.42$, $p<0.001$) and LA ($r=0.25$, $p<0.001$) samples.</p>

Stein et al. (2012)	N= 190 <u>Mean age:</u> 14 <u>Female:</u> 53% <u>Mexico:</u> 78% <u>US born:</u> 60%	<u>Design:</u> Cross Sectional Survey <u>Setting:</u> 3 NC schools	Discrimination: <u>Definition:</u> Discrimination was not defined. <u>Measure:</u> 19-items assessing for peer discrimination Acculturative Stress: <u>Definition:</u> Acculturative stress is “the stress that results from the interactions between different cultural groups” (p. 1340). <u>Measure:</u> BSS (Romero & Roberts, 2003)	Acculturative stress (r=0.22; p<0.05) and discrimination (r=0.35; p<0.05) were associated with depressive symptoms.
Stein & Polo (2014)	N= 159 <u>Mean age:</u> 13.1 <u>Female:</u> 50% <u>Mexico:</u> 100% <u>Nativity:</u> <u>US born:</u> 52%	<u>Design:</u> Cross sectional Survey <u>Setting:</u> 3 LA schools	Family Culture Conflict: <u>Definition:</u> Cultural Value Gap is “the differential incorporation of US values between parents and children” (p. 189). <u>Measure:</u> Subtraction of youth affiliative obedience from parent affiliative obedience score.	Affiliative obedience cultural value gap scores were associated with depressive symptoms ($\beta=0.26$, p<0.001).
Stein et al. (2016)	N= 71 <u>Mean age:</u> 15 <u>Female:</u> 50% <u>Mexico:</u> 60% <u>US born:</u> 53%	<u>Design:</u> Longitudinal Survey <u>Setting:</u> Southeast US Community	Discrimination: <u>Definition:</u> Perceived racial/ethnic discrimination was defined as “perceived unfair, biased, or discriminatory treatment by adults and peers in schools” (p. 263). <u>Measure:</u> Adult and Peer Discrimination Scale (Way, 1997)	Peer (b=0.11; p<0.01) and adult discrimination (b=0.16; p<0.01) was associated with depressive symptoms for Latino youth.
Wiesner et al. (2015)	N= 40 <u>Mean age:</u> 13.4 <u>Female:</u> 50% <u>Nationality:</u> Mexico: 82% <u>Nativity:</u> <u>US born:</u> 90%	<u>Design:</u> Cross sectional Survey <u>Setting:</u> 1 School in Texas	Family Culture Conflict: <u>Definition:</u> Mother-youth acculturation gap is defined as “differences in acculturation level between parents and their children” (p. 1). <u>Measure:</u> Difference in the Acculturation Rating Scale for Mexican Americans-II (Cuellar, Arnold, & Maldonado, 1995) for parents and children on Anglo and heritage culture orientations	Higher levels of mother-youth acculturation gap for mothers with Mexican orientation were associated with youth depressive symptoms (r=0.36; p<0.05).

Young et al. (2016)	<p>N= 90 <u>Age:</u> <16: 74% <u>Female:</u> 56% <u>Nationality:</u> Mexico: 32% <u>Nativity:</u> US born: 78%</p>	<p><u>Design:</u> Cross sectional Survey <u>Setting:</u> Rural pediatric primary care clinic in southern US</p>	<p>Discrimination: <u>Definition:</u> Perceived discrimination was not conceptually defined. <u>Measure:</u> Perceived Discrimination Scale (Whitbeck et al., 2001)</p>	<p>Perceived discrimination was associated with depressive symptoms (r=0.313; p=0.003).</p>
Zeiders et al. (2013)	<p>N= 323 <u>Mean age:</u> 15.3 <u>Female:</u> 50% <u>Nationality:</u> Mexico: 77% <u>Nativity:</u> US born: 72%</p>	<p><u>Design:</u> Longitudinal Survey <u>Setting:</u> 5 high schools in non-metropolitan Illinois</p>	<p>Discrimination: <u>Definition:</u> Perceived ethnic discrimination is “mistreatment based on differences from the majority culture on language and, in the case of individuals born outside the US, immigration status” (p. 953). <u>Measure:</u> Ten-item scale asking how often teens were affected by discrimination from general public, authority figures, and teachers (Whitbeck et al, 2001)</p>	<p>Perceived ethnic discrimination was associated with depressive symptoms in the short term for both males (r=0.46; p<0.001) and females (r=0.28; p<0.001), but were not significantly associated with depressive symptoms in the long term.</p>
<p><i>Note.</i> BSS = Bicultural Stress Scale (Romero & Roberts, 2003); HSI-AV = Hispanic Stress Inventory – Adolescent Version (Cervantes et al., 2012); LA = Los Angeles; NC = North Carolina</p>				

Table 2.2.
Cultural Stressors and Definitions

Cultural Stressor	Definition
Discrimination	Unfair, differential treatment based on ethnicity, including negative behaviors from others such as derogatory remarks, prejudicial treatment, and violence
Family Culture Conflict	Disagreement with a family member related to a discrepancy between their cultural values and those of the adolescent
Acculturative Stress	The stress that results from acculturation, which is the process of changing values and practices as a result of coming in contact with another culture
Bicultural Stress	The difficulties experienced when simultaneously navigating between one's heritage culture and a host culture
Intragroup Rejection	Becoming the recipient of negative behaviors and remarks from another individual within the same ethnic group
Immigration Stress	Challenges surrounding the event of immigrating to the new country
Context of Reception	"The opportunity structure, degree of openness versus hostility, and acceptance in the local community" (Schwartz et al., 2014, p. 2)

CHAPTER 3

Chapter 3 describes the results of a qualitative content analysis to determine which cultural stressors are currently experienced by contemporary Latina young women living in a tumultuous sociopolitical climate in the US.

Introduction

In addition to the stressors commonly experienced by all youth, Latino/a youth in the US experience cultural stressors, which are negative events uniquely experienced by members of ethnic minority groups (Stein et al., 2012). Although all Latinos/as may experience cultural stressors, adolescents are specifically vulnerable to these stressors as they are undergoing a period of identity development (Waterman, 1982). During adolescence, individuals become more aware of their cultural values and how others perceive those values, and thus become more susceptible to cultural stress (Delgado et al., 2011). Cultural stress experienced during adolescence may interfere with developing a bicultural ethnic identity (Torres & DeCarlo Santiago, 2017), which is protective against a variety of negative health outcomes (Neblett et al., 2012).

Cultural stress is associated with adverse psychological outcomes for Latino/a youth (McCord et al., 2018). Studies have found, for example, that having a parent with a vulnerable legal status is associated with negative emotional well-being for Latino/a children (Brabeck & Xu, 2010), and deportation of a parent is associated with a variety of negative psychosocial consequences (Brabeck, Lykes, & Hunter, 2014). Ethnic discrimination (Cano et al., 2015; Cervantes, Cardoso, & Goldbach, 2015; Piña-Watson & Castillo, 2015) and a

negative context of reception, or feeling that one is not welcomed in their local community (Cano et al., 2015; Schwartz et al., 2014), have been linked to depressive symptoms in Latino/a youth. Conflict between parents and children stemming from differences in acculturation is also associated with depressive symptoms among Latino/a youth (Cervantes et al., 2015; Cervantes, Córdova Jr, Fisher, & Napper, 2012; Piña-Watson & Castillo, 2015).

Cultural stress may be more intense for Latina young women than Latino young men (Piña-Watson et al., 2013). Due to the focus on familismo, or family centeredness, in the Latino/a culture and strict behavioral expectations that many Latino/a parents have for their daughters, Latina young women frequently experience conflict with their parents as they enter adolescence and desire more autonomy (Zayas, Gulbas, Fedoravicius, & Cabassa, 2010; Zayas & Pilat, 2008). Discrepancies between parents' and their daughters' beliefs on traditional gender roles are associated with depressive symptoms for Latina young women (Piña-Watson et al., 2013). Because Latina young women may be more affected by family conflict (Zayas et al., 2010; Zayas & Pilat, 2008) and more likely to experience mental health problems such as depressive symptoms and suicidal ideation than Latino young men (CDC, 2016), research is needed to determine what cultural stressors Latina young women face in the current US sociopolitical climate.

Over the last three years, strict immigration policies and negative political rhetoric towards immigrants have increased stress for many Latinos/as living in the US. Beginning with the announcement of Donald Trump's presidential

candidacy in summer 2015, he has made a variety of statements, particularly directed at immigrants from Mexico, that members of the Latino/a community were “criminals” and “rapists” and that a border wall would be built between Mexico and the US (Desjardins, 2018, January 12). These comments have been coupled with harsh immigration policies such as increased Immigration and Customs Enforcement activity (Department of Homeland Security, 2017, Feb. 21), terminating Temporary Protected Status for immigrants from Nicaragua, El Salvador, and Honduras (Department of Homeland Security, 2018, March 9), and rescinding of the Deferred Action for Childhood Arrivals program (DACA; Department of Homeland Security, 2017, Sept. 5). Sociopolitical messages such as these can filter down to the interpersonal level and set the tone for how minority populations are received in society (Bourhis et al., 1997). Just prior to Donald Trump’s inauguration, 47% of Latinos/as indicated they worried “a lot” or “some” about themselves or loved ones being deported, and 41% of Latinos/as indicated they were worried about their place in the US with the new Trump administration (Pew Research Center, 2017b). One recent study also found that Latino/a immigrant parents frequently worried about immigration-related adversity under the Trump administration, and those with more intense immigration-related worries were more likely to experience psychological distress (Roche, Vaquera, White, & Rivera, 2018).

From an anecdotal perspective, individuals working with Latino/a youth in a variety of settings have observed how anti-immigration policies and heightened negative attitudes towards the Latino/a community in the US are negatively

affecting Latino/a youth. A variety of news articles have been published in the last two years about school teachers managing the stress of Latino/a youth in the classroom (Gumbel, 2016, November 25; Kamenetz, 2017, March 9) and doctors seeing increases of anxiety and fear in their young Latino/a patients (Klivans, 2017, April 19; Planas & Carro, 2017, March 1). Professional societies have also issued statements urging the medical community to protect immigrant youth from the toxic stress that many are experiencing as a result of the current sociopolitical climate (Stein, 2017; Svetaz & Coyne-Beasley, 2017). Because experiences with cultural stressors such as discrimination and fears of deportation have likely intensified from 2015, systematic documentation of how contemporary Latina young women experience these stressors is needed.

Previous research on Latino/a youth has not accounted for how experiences of cultural stress vary by generational status. Immigrants are often classified by generational status as a proxy measure of their level of acculturation, or the degree to which they have adopted aspects of a new culture (Berry, 2003). Individuals are classified as first generation (born outside the US), second generation (one or both parents born outside the US), and third or higher generations (one or more grandparents or beyond born outside the US; United States Census Bureau, 2016). As generational status increases, individuals tend to have a higher level of acculturation to a host culture, and level of acculturation has been associated with specific attitudes, behaviors, and health outcomes (Thomson & Hoffman-Goetz, 2009). Latinas of differing generational statuses, thus, may be more or less vulnerable to different cultural stressors. For instance,

first- and second-generation Latina young women may be more vulnerable to cultural stressors due to struggles with acculturation (Ramos, 2004) than third- and fourth- generations, who are progressively less likely to self-identify as Latino/a (Pew Research Center, 2017a). In research on cultural stress in Latino/a adolescent populations, researchers typically only classified their participants into “US born” and “foreign born” (Cervantes et al., 2012; Stein et al., 2012), only recruited first generation youth (Cano et al., 2015; Schwartz et al., 2015), or have not accounted for generational status at all (Forster et al., 2013). Since Latino/a youth of varying generational statuses may have different levels of acculturation and experiences with cultural stressors, there is a need to understand how perceptions of cultural stress vary by generational status.

Given that recent changes in the sociopolitical climate in the US have likely exacerbated the cultural stressors experienced by Latina young women, and these stressors are likely to vary by generational status, more information is needed about the current stressors experienced by different generations of Latina young women. The purpose of this study is to describe cultural stressors experienced by Latina young women of different generational statuses by systematically analyzing narratives drawn from a larger study of depression in this population. Because the narratives provide rich accounts of the young women’s day-to-day lives, they offer a unique glimpse into factors that concern them and affect their well-being.

Methods

Parent Study

The data for the current study is drawn from a larger qualitative study examining how Latina young women experience, self-manage, and seek mental health services for their depressive symptoms during their adolescent years. Participants in this study were young Latinas (n=24) aged 13-20 living in a large city in the Midwest. All participants self-identified as female and Latina, were fluent in English, and reported experiencing depressive symptoms during their adolescent years. Some participants were recruited by fliers placed throughout the local community and some were recruited from a primary care clinic and had been identified as having a clinical history of depression. Individuals were excluded from participating in the study if they were experiencing imminent thoughts of self-harm or a significant amount of mental distress.

Parental consent and adolescent assent were obtained for adolescent participants (ages 13 to 17), and informed consent was obtained for young adult participants (ages 18 to 20) prior to the interviews. To maintain participant confidentiality and ease any concerns about signing documents in the current sociopolitical climate, the principal investigator obtained a waiver of documentation of consent and assent and did not use participants' names on any study documents. The participants were given a brief demographic questionnaire (Appendix B) to complete before the interview, and qualitative data was collected via semi-structured interviews driven by an interview guide (Appendix C). A distress protocol was used in the event that the participant became acutely

distressed or if safety issues arose during the interview (Appendix D; Draucker, Martsolf, & Poole, 2009). After completing the interview, each participant was given a \$30 gift card as compensation. All procedures were approved by the IRB at the investigators' university.

Interviews were conducted in English, audio-recorded, and lasted approximately one hour. All interviews took place in private rooms in public locations outside of the participants' homes but within their local communities. Interviews began with broad questions regarding the participants' experiences with their depressive symptoms and transitioned to more focused questions to clarify previous information discussed by the participant and ensure that other important information related to the study aims was collected. The interview guide (Appendix C) also included a question asking the participants to reflect on the stress they felt as a result of being a Latina currently living in the US. The responses to this question, as well as the discussion of any other cultural stressors noted in the complete interview transcripts, were used for analysis in the current paper.

Current Study

A qualitative descriptive design (Sandelowski, 2000) guided this study. Qualitative description is a low-inference way of representing the phenomenon of interest in the everyday words of the participants. A qualitative descriptive design was chosen in order to obtain a straightforward depiction of the common stressors Latina young women are experiencing in the current US sociopolitical climate.

Qualitative content analysis techniques (Miles et al., 2014) were employed to analyze the data in this study. Content analysis is the typical method of data analysis in qualitative descriptive studies (Sandelowski, 2000). Transcripts were read in entirety by the principal investigator and another member of the student's project team with expertise in qualitative methods, specifically focusing on how the Latina young women described the stressors they were experiencing as a result of their Latina culture or the current sociopolitical climate. A content analytic summary table (Miles et al., 2014) was used to aid the qualitative coding process. A content analytic summary table is a form of data matrix that gathers all textual data related to a specific topic into a single table to more easily identify commonalities across the experiences of all participants (Miles et al., 2014). Any description of stress related to culture or the current sociopolitical climate was copied into the content analytic summary table and separated by generational status. For this analysis, the principal investigator did not include information about the stressors participants described that were common to young women more generally and not clearly related to their cultural background, such as general family discord or typical peer conflicts. The principal investigator grouped similar codes together into categories and gave them names and definitions. The principal investigator and the expert in qualitative methods met weekly to discuss the codes and emerging categories. If there were disagreements regarding codes and categories, they returned to the data and engaged in discussion until consensus was achieved. The principal investigator wrote memos throughout the data analysis process to maintain an audit trail of analytic decisions (Charmaz,

2014). Another member of the student's project team, who commonly works with Latina youth in the local community, was involved in the data analysis process to determine if the emerging categories resonated with her experience with this population (Charmaz, 2014).

Results

A total of 24 Latina young women were interviewed in the study. The mean age of participants was 16.7 years with a range of 13-20 years. Eight participants were recruited from primary care, and 16 were recruited from community settings. Eight participants were first-generation immigrants, 14 were second-generation immigrants, 1 was a third-generation immigrant, and 1 was a fourth-generation immigrant. For first-generation immigrants, the average time in the US was 10.14 years with a range of 5-12 years. Most participants were of Mexican origin (63%), as is consistent with the demographics of the area. Three participants identified as Salvadoran, two as Puerto Rican, one as Venezuelan, one as Nicaraguan, one as Tejano, one as Honduran, one as Cuban, and one as Colombian.

The participants provided rich descriptions of stressors they experienced due to their cultural background and as a result of the current political climate. Four types of cultural stressors were described by the participants: 1) parental oversight, 2) pressure to succeed, 3) being treated differently, and 4) fear of deportation.

Parental Oversight

Seventeen participants described the stressor of parental oversight within the context of the Latino/a culture. This stressor could include over involvement or under involvement by parents in the participants' lives. First- and second-generation participants discussed both forms of parental oversight, while third- and fourth-generation participants did not discuss this stressor.

Many participants described how typical Hispanic parents are overinvolved in their daughter's lives due to "overprotectiveness," either to keep their children safe or due to reliance on traditional values. Some participants had conflicts with their parents over having boyfriends and "hanging out" with friends. One second-generation participant said, "I feel like my dad is just like other Hispanic parents. ...I was dating somebody, and he found out, and he just didn't like it at all." A few participants described times when their parents held younger siblings to different standards, causing even more frustration for the participants. One participant explained, "Now my sister wanders the whole neighborhood and they don't care. That got me upset. ...I wasn't allowed to do all that stuff when I was younger." Second-generation participants were more likely than first-generation participants to describe their parents as "strict." One second-generation adolescent described ongoing conflict with her mother:

In Mexico, that's like traditional that you shouldn't show pictures of where you live or FaceTime™ at your house because that's bad because they might come and rob you and stuff like that. But I understand that's how it is in Mexico but... you're here now, and people are different here than they are there. They're not all the same. She [mom] thinks the same way. She always gets mad at me or like even if I take like a black photo....She gets mad about that. So there's always conflict.

Other participants felt like they had little parental oversight because their parents were often out of the home due to job responsibilities. One second-generation participant explained why she thought Latino/a parents are often absent: "Mexican parents...focus a lot on working as much as they can to get as much money as they can for their kids. So they might not be there for them because that happens." Participants whose parents were often absent took on extra responsibilities around the house and cared for younger siblings. One second-generation participant described her responsibilities while her father was working: "I took care of my siblings and that was really hard because I wanted to go with my friends and do other stuff, but I had to focus on my siblings." Participants in the first-generation discussed having absent parents more so than second-generation youth. One first-generation participant whose father had been deported described her struggle to help her mom maintain the household:

It's just really hard, especially with my mom. She has two jobs, and she's really trying, and I'm really trying to help her with everything, like keep the house clean, take care of my sister. Nobody is taking care of us. We're really trying to help her.

Pressure to Succeed

Seventeen participants discussed the stressor of the pressure to succeed as it relates to their Latino/a culture. Pressure to succeed refers to the stress that the participants felt in attempting to live up to expectations related to the opportunities that were afforded to them in the US, particularly in relation to education. Participants understood that their families expected much from them because their parents and grandparents did not have the same opportunities when they were growing up abroad. One second-generation adolescent

described this pressure: "My mom looked to me, since I'm the youngest and I was still going to school, so it was just so much pressure already, how she was looking forward to me succeeding." Several participants were told that as minorities they needed to work harder than White peers to reach the same goals. One second-generation young woman stated, "As a brown person, you need to take two steps for every one step a White person takes so that makes things more difficult."

This pressure to succeed was felt by first-, second-, and third-generation participants with slight variations. First-generation participants described how they felt pressure to succeed specifically because their parents gave them better opportunities by immigrating to the US. After struggling in one of her classes, one first-generation adolescent was told by her parents, "[W]e're giving you a very good opportunity here, because we really didn't have this when we were growing up." Second- and third-generation participants felt more general pressure from their parents to graduate from high school, go to college, and make their family "proud" of their academic achievements. Their parents expected them to be "great" and remain "at the top of the class." One second-generation adolescent stated, "[Mom] wants to see me be at least top three, and right now I'm top 100, but I'm still at 65, so that's kind of going to be really hard." However, the fourth-generation participant did not experience this pressure. She stated, "I've heard of it [pressure to succeed] because I have friends who felt that sort of pressure, but I didn't personally feel any."

One first-generation participant who immigrated to the US from Puerto Rico described her struggle with schoolwork, capturing the multifaceted phenomenon of pressure to succeed among young Latinas:

I was a disciplined student in Puerto Rico, so I got good grades. Then coming here, my 4.0 had dropped to a 2.8 and that is not okay for Hispanic parents. So for them [parents] before it used to be like, "Oh, no, you've got to make something of yourself." When we came here it changed to, "Oh, no, you've got to show these White people that you're smart too and that you're also valuable." I kind of felt like I had a whole responsibility of representing my race.

Being Treated Differently

Fifteen participants described the stressor being treated differently due to their Latina background. This stressor included both internal feelings of being different from peers as well as receiving differential treatment from others on the basis of ethnicity. Some participants at times felt "weird" or "the odd one out" in relation to their peers, and many had been subjected to acts of discrimination, microaggressions, and stereotyping. Participants had been told to "go back home," were stereotyped as being sexual, and made fun of for being Spanish-speaking. One first-generation young woman described an experience with discrimination: "This kid started making fun of my long last name because I have two last names. He started adding words like 'oh taco' and, I don't know, like really stereotypical Spanish words. I got really mad." Participants also described being treated differently by White people as well as other Latinos/as. One participant explained, "If you're White passing, it's a different experience than not being just because the people who are supposed to be your people don't really

identify with you, and it's understandable because I experience privilege more than they would."

Being treated differently was experienced by the first-, second-, and third-generation participants, but varied more by skin color and degree of ethnic diversity in their communities than by generational status. Individuals who identified themselves as more "White passing" felt they were less likely to be treated differently than their darker-skinned peers. One second-generation participant stated, "People questioning how my mom is my mom, because we're very different in skin tone, I'm very White compared to her, and so sometimes they discriminate [against] her." Participants who attended schools and lived in communities where there was more diversity experienced less of a sense of being treated differently than those who did not interact often with other Latinos/as. A second-generation participant described the environment at her school: "[T]here were a lot of White people, there were a lot of Black people, but there weren't a lot of Hispanics, and so I guess maybe that's one of the reasons I felt kind of left out."

First-, second-, and third-generation participants thought that Latinos/as might be treated differently more now than they had been in the past due to the current sociopolitical climate. One second-generation young adult shared her thoughts on how younger Latinos/as might be affected by the Trump administration:

Back then there was no such thing as bad stuff for Mexicans or Latinos as it is right now because of, I don't want to mean or anything, because of our President and because of all that stuff that has happened. But as far as I remember when I was younger there

was no problem of me being a Latina and Hispanic living here in the States. So as far as I remember, it's been nice, but I can't really talk much for this generation...

Fear of Deportation

Eight participants, first- and second-generation only, discussed the stressor of the fear of deportation. First-generation youth feared deportation for both themselves and family members. Second-generation youth specifically worried about the deportation of their family members and friends. Several participants were worried based on the current administration's calls for changes in immigration policies. Participants felt a great deal of uncertainty about what would happen to their families and had a general sense that deportation was completely out of their control. One first-generation participant whose father was being detained stated, "I know that someday they are going to end up taking him back to Mexico. There is nothing you can actually do." One second-generation adolescent participant stated, "Since Trump got voted, I've been constantly worried about my parents being taken.... And then when I think about that, that makes me want to cry." Another second-generation participant stated, "I have friends too, that go to my school that aren't from here, and with DACA and everything, what's happening, they have to worry about that. Like are they going to get sent back?" Both first- and second-generation participants realized that they may have to "step up" and care for remaining family if parents were deported. One first-generation participant whose father had been deported stated:

Please don't take my mom. I really need her in my life. Since my sister was born here, I was afraid of like them taking her

[participant's mother] and we just leave her. It was my biggest fear. I just couldn't really imagine the police taking my mom. And just my brother and me, trying to take care of my sister. ...I just hope that I can actually see my dad at least one more time, and just hope that no one takes my mom away from us.

A few first-generation participants also discussed fears about what their future held in the US as an undocumented immigrant. One first generation adolescent stated, "I would be like really scared a lot. What if I can't go to college here? Or one day something bad happens, and I need this and this that I don't have, because I'm not from here."

To cope with these fears, participants relied on informal community networks to communicate information about increased local deportation activity. One participant described one such network: "Some of her [mom's] friends have told her, 'Oh, police are checking for papers today'... so we warn each other and help each other out and stuff, so we won't get caught." Some individuals also described how they relied on their religious faith to ease fears of deportation. One first-generation adolescent stated, "[T]he whole Donald Trump thing, becoming president, they [parents] were all worried, but ... it's what God wants, like if he wants us to go back for some reason, and if he doesn't, he won't let us."

Discussion

Participants in this study described a variety of cultural stressors, some of which have been discussed in previous literature. For example, participants' descriptions of parental "overprotectiveness" are consistent with prior research that indicates that Latino/a youth experience conflict with parents as a result of differences in levels of acculturation as it relates to youth autonomy (Cervantes

et al., 2015; Cervantes et al., 2012; Piña-Watson & Castillo, 2015), and this stress is often more intense for Latina young women due to strict gender roles (Piña-Watson et al., 2013). The stressor of parental absence due to work demands has been less frequently studied, although it is documented that Latino/a families frequently immigrate to the US to provide their families with better economic opportunities (Bacallao & Smokowski, 2007; Roche et al., 2018), and Latino/a parents often depend on dual incomes to support their families after immigration (Bacallao & Smokowski, 2007). Latino/a parents have also reported difficulties being involved their children's education due to demanding work schedules (Ryan, Casas, Kelly-Vance, Ryalls, & Nero, 2010; Zarate, 2007). The stressor of parental oversight represents the intersection of culture and low socioeconomic status for this population (Zayas et al., 2010). Future research should explore in more depth how parents being absent from the home due to demanding work schedules acts as a cultural stressor for Latina young women.

The finding that experiencing intense pressure to succeed was a prominent cultural stressor for Latina youth has not been extensively addressed in the existing literature, despite the fact that many Latino/a families immigrate to the US so that their children can have access to better educational opportunities (Roche et al., 2018). One study documented that Latina young women commonly felt familial pressure to succeed, which contributed to their level of stress (Lopez-Morales, 2008). Instruments measuring cultural stress for Latino/a youth, such as the Bicultural Stress Scale (BSS; Romero & Roberts, 2003) and Hispanic Stress Inventory-Adolescent Version (HSI-AV; Cervantes et al., 2012), however, do not

measure pressure to succeed for Latino/a youth. This concept should undergo further conceptual development and instrumentation so that it can be measured in future research with Latino/a young people.

Consistent with study findings regarding the cultural stressor of being treated differently, many studies have demonstrated that experiencing ethnic discrimination (Cano et al., 2015; Cervantes et al., 2015; Piña-Watson & Castillo, 2015) and intragroup rejection (Basañez, Warren, Crano, & Unger, 2014; Piña-Watson et al., 2015a) were associated with negative mental health outcomes for Latino/a youth. Similarly, just as the participants in this study noted that variations in the experience of being treated differently were related to their skin color, experts have discussed how lighter skin tones have been associated with more privilege than darker skin tones among Latinos/as (Adames, Chavez-Dueñas, & Organista, 2016; Chavez-Dueñas, Adames, & Organista, 2014). Consistent with the findings of the current study, several studies have also demonstrated that living in a neighborhood with a White majority is associated with increased experiences of discrimination toward minority residents (English, Lambert, Evans, & Zonderman, 2014; Hunt, Wise, Jigguet, Cozier, & Rosenberg, 2007), and students attending ethnically diverse schools with no clear majority population experience less discrimination (Seaton & Douglass, 2014). This study's findings add to this literature by suggesting that experiences of being treated differently may be more pronounced under the current US political administration.

Although studies conducted prior to Donald Trump's campaign demonstrated that parental deportation negatively impacts the mental health of Latino/a youth (Gulbas et al., 2016; Rojas-Flores, Clements, Hwang Koo, & London, 2017; Zayas & Bradlee, 2014), research is needed to determine how these effects may be exacerbated in the current sociopolitical climate. Roche et al. (2018), for example, revealed that Latino/a parents now avoid seeking health services for their families and warn their children to evade the authorities due to fears of deportation. Additionally, Latina young women in this study perceived a lack of control over the deportation of themselves and their family members. Previous research demonstrated that having a sense that external events are out of one's control, or an external locus of control, is associated with negative mental health outcomes (Culpin, Stapinski, Miles, Araya, & Joinson, 2015), specifically for young women (Jain & Singh, 2015). This study's findings provide evidence in participants' own words that fears of deportation of oneself or one's parents can be consuming for some Latina young women and that their distress may be further compounded if they feel they have no control over deportation outcomes.

The current study findings provide a preliminary indication that a variety of cultural stressors affect the day-to-day lives of Latina young women, often in pronounced ways, and that these stressors are exacerbated in a sociopolitical climate that calls for strict immigration policies and is marked by negative political messaging about immigrant populations. Further research is needed to determine the prevalence with which the cultural stressors identified in this study

are experienced by Latino/a youth across the US and how these stressors are associated with negative psychological outcomes. Future research addressing these topics should also be inclusive of gender, US geographical location, generational status, and documentation status.

Limitations

The current study has several limitations. First, the Latina young women in the sample all had experienced depressive symptoms and thus may have had more pronounced experiences with the cultural stressors that were identified than their non-depressed peers. Moreover, the study was limited by the inclusion of only one third- and one fourth-generation participant, limiting the conclusions that can be drawn about variations in experiences of cultural stressors by generational status. Additionally, the principal investigator did not ask participants about documentation status in order not to introduce suspicions about the intent of the research and could not therefore systematically examine how individual or family documentation status might have impacted participants' experiences with cultural stressors.

Clinical Implications

Practitioners working with this population should be aware of the cultural stressors identified in this study and provide Latina young women with a safe space in which to discuss their stressful experiences (Svetaz & Coyne-Beasley, 2017). Healthcare providers, in particular, should inquire how the young women are coping with cultural stressors and discuss ways they might manage these stressors. For Latina young women who are suffering from significant

psychological distress as a result of cultural stressors, healthcare providers should refer them to mental health providers with expertise working with this cultural group. Practitioners working with Latina young women in a variety of settings can also assist them in developing a better sense of control over the stressors they are experiencing through goal setting activities, making plans to achieve their future goals, and providing families with resources to address immigration-related concerns. Individuals working with Latina young women should be knowledgeable of resources available for undocumented families such as the National Immigration Law Center (n.d.) and local non-profit organizations that may provide legal assistance to Latino/a immigrant families.

Policy Implications

The American Academy of Pediatrics and Society for Adolescent Health and Medicine have issued statements regarding the impact of the current sociopolitical climate on the health of immigrant youth (Stein, 2017; Svetaz & Coyne-Beasley, 2017). These organizations call for healthcare providers to advocate for public policies that protect immigrant youth from the toxic stress that has resulted in the wake of the current administration's attitudes and policies towards immigrants (Stein, 2017; Upadhyia & Coyne-Beasley, 2017). Professional codes of ethics also call for mental health providers, nurses, and social workers to advocate for social justice when patients are impacted by discriminatory policies that negatively impact their physical and mental health (American Counseling Association, 2014; American Nurses Association, 2010;

American Psychological Association, 2016; National Association of Social Workers, 2017).

Conclusion

This study is one of the first to systematically document the cultural stressors that are currently being experienced by Latina youth in a sociopolitical climate that is hostile towards immigrant families. In addition to other cultural stressors they have experienced throughout their lives, the Latina young women in this study identified having increased fears of deportation and more noticeable experiences of being treated differently under the current administration. Due to the negative psychological outcomes associated with cultural stress for Latino/a youth, healthcare providers have a duty to address experiences of cultural stress in their practice with Latino/a young people and advocate for policies that will ultimately result in improved mental health for Latino/a immigrant youth living in the US. Future research should address how cultural stressors such as those identified in this paper impact the mental health of Latina young women and how they manage their responses to these stressors.

CHAPTER 4

Chapter 4 describes the results of a grounded theory study and the development of a theoretical framework that describes how Latina adolescents experience, self-manage, and seek mental health services for their depressive symptoms.

Introduction

Latino/a adolescents, especially Latina adolescents, experience higher rates of depressive symptoms than their Caucasian and African American peers. According to the YRBSS, 46.7% of Latina adolescents reported feeling sad and hopeless on a daily basis, in comparison to 37.9% of Caucasian adolescent girls and 33.9% of AA adolescent girls (CDC, 2016). These high rates of depressive symptoms are associated with serious health consequences, in particular suicidality (Zayas, Lester, Cabassa, & Fortuna, 2005). In 2015, 25.6% of Latina adolescents reported suicidal ideation, and 15.1% reported a suicide attempt in the past year (CDC, 2016). In comparison, 22.8% of Caucasian and 18.7% of AA adolescent girls reported suicidal ideation, and 9.8% of Caucasian and 10.2% of African-American adolescent women reported a suicide attempt (CDC, 2016). In addition to suicidality, risk behaviors such as cigarette smoking (Lorenzo-Blanco et al., 2011; Nezami et al., 2005), substance use (Schwartz et al., 2015), and rule-breaking behavior (Cano et al., 2015; Delgado et al., 2011) have been associated with depressive symptoms in Latina adolescents.

Both universal and cultural stressors contribute to this high rate of depressive symptoms for Latino/a adolescents. Universal stressors are those

that impact all adolescents, regardless of race or ethnicity (Stein et al., 2012), such as general family conflict (Kelly et al., 2016; Restifo & Bogels, 2009), peer victimization (Hawker & Boulton, 2000; Kelly et al., 2016; Stapinski et al., 2015), and economic difficulty (Santiago, Wadsworth, & Stump, 2011). Latino/a adolescents also experience cultural stressors in addition to the universal stressors that all youth may face. Cultural stressors are negative events that are experienced due to being a member of a particular ethnic population (Cano et al., 2015; Cervantes, Cardoso, & Goldbach, 2015; Garcia-Coll et al., 1996; Stein et al., 2012). Discrimination (Cano et al., 2015; Lorenzo-Blanco et al., 2011; Potochnick, Perreira, & Fuligni, 2012; Potochnick & Perreira, 2010; Schwartz et al., 2015; Schwartz et al., 2014), family conflict over cultural values (Cervantes et al., 2015; Cervantes, Fisher, Cordova, & Napper, 2012; Lorenzo-Blanco et al., 2012; Lorenzo-Blanco & Unger, 2015), perceived lack of opportunity in the US (Cano et al., 2015; Schwartz et al., 2015; Schwartz et al., 2014), and immigration difficulties (Cervantes et al., 2015; Cervantes et al., 2012; Potochnick & Perreira, 2010) are all cultural stressors have been associated with the depressive symptoms in Latino/a youth. A few studies have also shown that Latina young women, in comparison to Latino young men, experience increased depressive symptoms related to the stress that results from family conflict (Hankin et al., 2007; Zayas & Pilat, 2008) and discrepancies between parents' and their daughters' beliefs about traditional gender roles for women (Céspedes & Huey, 2008; Piña-Watson et al., 2013). The convergence of all these stressors on

Latina young women contributes to the high rate of depressive symptoms in this population.

Despite having high rates of depressive symptoms, Latina adolescents are less likely to receive treatment for depression than their White peers. According to SAMHSA, 34% of Latino/a adolescents experiencing an episode of Major Depressive Disorder (MDD) in 2016 received mental health treatment for depression, in contrast to 45% of White adolescents (SAMHSA, 2015).

Latinos/as are also more likely to see a primary care provider than a specialized mental health provider when they seek treatment for mental health concerns (Council of National Psychological Associations for the Advancement of Ethnic Minority Interests, 2003; Garland et al., 2005; Vega, Kolody, & Aguilar-Gaxiola, 2001). In terms of receiving specific mental health treatments, Latinos/as are less likely to be prescribed antidepressants (Cummings & Druss, 2011; Kirby, Hudson, & Miller, 2010; Miranda & Cooper, 2004) or receive psychotherapy (Chen & Rizzo, 2010) than Caucasian Americans. Although many studies have established that the Latino/a population experiences disparities in receiving mental health treatment for depression, little work has been done to develop strategies that will increase mental health treatment utilization in this population (Alegría et al., 2008; Davidson et al., 2015).

Although several evidence-based treatments exist to treat adolescent depression, such as cognitive behavioral therapy, interpersonal psychotherapy, and antidepressant medications (Clark et al., 2012; David-Ferdon & Kaslow, 2008; TADS Team, 2007), few of these treatments have been modified to

address the unique experiences of Latino/a adolescents (Hooper et al., 2016; Huey & Polo, 2008). Because culture affects the manifestation, identification, and treatment of mental health problems, many experts agree that cultural modification of evidence-based mental health treatments is needed (Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Bernal & Scharró-del-Río, 2001; Canino & Alegría, 2008; Comas-Díaz, 2006; Hooper et al., 2016). Because Latino/a adolescents in the US live within a unique sociocultural environment that affects the development of mental health problems and how these individuals seek and use mental health services (Davidson et al., 2015; Goldston et al., 2008), mental health treatments need to be adapted to meet the unique needs of Latino/a adolescents specifically (Bernal et al., 2009; Bernal & Scharró-del-Río, 2001; Chu et al., 2016; Davidson et al., 2015; Lau, 2006). Latino/a adolescents needing mental health services may not seek them or be engaged in treatment if the services that are offered by healthcare providers do not address their unique experiences (Chu et al., 2016).

While many studies have established that Latina adolescents face mental health disparities in regards to depressive symptoms and mental health treatment utilization, few studies have explored how Latina adolescents experience and self-manage their depressive from their own perspective. Several decades ago, there was a call for researchers to develop a better understanding of the subjective experiences of Latino/a youth facing depression (Castañeda, 1994). Although many studies have described mental health disparities for Latino/a youth and identified factors associated with depressive symptoms in

Latino/a adolescents since that time, the personal experiences of Latina adolescents with depressive symptoms have not been examined in detail. A few qualitative studies have addressed Latinos'/as' perceptions and knowledge of depression (Barrera, Schulz, Rodriguez, Gonzalez, & Acosta, 2013; Fornos et al., 2005; Garcia & Lindgren, 2009b) and barriers to mental health treatment (Karasz & Watkins, 2006; Uebelacker et al., 2012), but no studies have specifically examined how depressive symptoms unfold over time from the perspective of Latina adolescents. Additionally, the ways by which Latina adolescents self-manage their depressive symptoms and seek mental health services has not been well-examined (Lopez et al., 2008).

In order to develop culturally sensitive strategies to prevent, identify, and treat depressive symptoms in this population, it is necessary to understand how depressive symptoms, self-management, and treatment seeking unfold over time from the perspective of Latina adolescents. The purpose of this study was to develop a theoretical framework that describes how Latina adolescents experience, self-manage, and seek treatment for depressive symptoms.

Methods

Design

Constructivist grounded theory methods (Charmaz, 2014) were used to develop a theoretical framework that reflects the experience of young Latinas suffering from depressive symptoms during their adolescent years. Grounded theory methods include the systematic, yet flexible, collection and analysis of qualitative data with the goal of developing a theoretical framework that is

grounded in the data (Charmaz, 2014; Glaser & Strauss, 1967). Under a constructivist approach, it is assumed that the researcher and participants bring their past experiences to data collection and construct reality together. This approach is based on the tenet that instead of truth being absolute, it is socially constructed through the research process (Charmaz, 2014). The resulting grounded theory framework explains psychosocial processes that change over time and situates those processes in a specific social context (Bryant & Charmaz, 2010; Charmaz, 2014; Glaser & Strauss, 1967). Because the unfolding of depressive symptoms over adolescence is a psychosocial process and the Latino/a community and culture serves as the context for adolescent young women's experiences of depressive symptoms, grounded theory methods were chosen to answer the research questions.

Sample and Setting

The participants in this study were young Latinas (ages 13-20) who were currently experiencing depressive symptoms (adolescent participants ages 13 to 17) or had depressive symptoms during their adolescent years (young adult participants ages 18-20). The principal investigator wished to obtain narratives from young Latinas who had experienced a broad range of depressive symptoms as adolescents, had and had not experienced formal mental health treatment, and had and had not told parents or adults about their depressive symptoms. Participants were therefore recruited purposively from two groups and from several settings (Charmaz, 2014; Karasz & Watkins, 2006). Latina adolescents (ages 13 to 17) were included in the sample to discuss their contemporaneous

experiences with depressive symptoms, and Latina young adults (ages 18 to 20) were included to discuss their experiences with depressive retrospectively, with the assumption that they would be able to discuss their adolescent experiences with some distance and perspective. In addition, young adults could participate without parental consent. The sample was recruited from a primary care clinic and several community settings in a large, urban city in the Midwest.

To be eligible for the study, participants 1) were female, 2) self-identified as Latina, 3) spoke English fluently, and 4) reported depressive symptoms during their adolescent years. In addition, participants from the primary care setting had a documented clinical history with depression (e.g., MDD, DD, or Depressed Mood). Participants were excluded from the study if they were currently experiencing a mental health crisis or imminent thoughts of self-harm.

Recruitment

Participants from the community setting were recruited by study fliers placed throughout the community in venues that young Latinas were likely to gather (e.g. community centers, libraries, churches, a local college campus, and coffee shops). The study was also announced at local programs serving Latina adolescents. The fliers indicated that the principal investigator would like to interview Latinas between the ages of 13 and 20 who had experienced depressive symptoms during their adolescent years, displayed a list of depressive symptoms in everyday language, and included a number to contact the investigator. Other participants were recruited from a local primary care clinic serving a large Latino/a population. The principal investigator worked with

primary care providers at the clinic to identify young women with a clinical history of depression who may be eligible for the study. Providers introduced the study to potential participants, and if interested, invited the investigator to describe the study in further detail.

Participants who saw the flier in community settings and were interested in the study called a toll-free phone number. Upon calling this number, they were interviewed for eligibility by the principal investigator. A distress screening guide (Appendix A) was used prior to enrolling participants in the study to ensure that they were not in acute distress (Draucker, Martsof, & Poole, 2009). If potential participants from the clinic setting were interested in the study, the investigator met with them during their visit, described the study in detail, and verified that they met eligibility criteria. Verbal adolescent assent and parental permission was obtained for adolescent participants, and informed consent was obtained from young adult participants. All study procedures were approved by the IRB at the investigators' university.

Data Collection

Data were collected by semi-structured interviews. The interviews were scheduled in public locations with available private rooms within participants' local communities. The interviews were driven by an interview guide (Appendix C) and conducted in English. Interviews began with questions related to the participants' overall experiences with their depressive symptoms and transitioned to focused questions to clarify previous statements and collect further data related to the aims of the study. Examples of interview questions included: "Tell

me about what was going on in your life the first time you experienced depressive symptoms”; “What was something you did to make yourself feel better during that time?” and “Tell me about who you talked to about your depressive symptoms during that time.” To ensure that all relevant information was collected, the participant and interviewer also constructed a timeline together to reflect how the participant’s depressive symptoms, self-management behaviors, and mental health treatment seeking unfolded and changed over time in relation to each grade level in school. In the event that a participant became distressed or if safety concerns arose during the interview, a distress protocol was available to guide the response of the interviewer (Appendix D; Draucker et al., 2009). The interviews were audio-recorded and transcribed verbatim.

Data Analysis

Analytic procedures as described by Charmaz (2014) and consistent with grounded theory were used on the interview narratives. Charmaz (2014) describes four stages of coding. The first stage of coding is initial coding, which is the process of examining small segments of data and expressing them as actions in the gerund verb tense (Charmaz, 2014). The principal investigator performed this coding on the interview transcripts, and the initial codes were verified by another member of the student’s project team, an expert in qualitative methods. Once initial coding was underway, focused coding began. Focused coding involves comparing initial codes between transcripts to reveal patterns in the data and sorting these codes into categories based on identified patterns, taking the data to a more conceptual level (Charmaz, 2014). During focused

coding, the principal investigator began grouping similar initial codes together into tables in Microsoft Word™ and writing theoretical memos to describe her thoughts about how the initial codes were related. At weekly meetings, she presented these emerging focused codes to the expert in qualitative methods who provided thoughts and feedback based on her reading of the transcripts. During axial coding, the properties and attributes of the emerging categories are generated (Charmaz, 2014). Throughout the process of axial coding, the principal investigator wrote memos to document her thoughts on the attributes and properties of the emerging categories. She also engaged in frequent discussions with the qualitative methods expert who provided feedback on axial coding. In grounded theory, the coding process is iterative with different levels of coding being completed at the same point in time, so constant comparative methods were also used to compare new interview data with previously collected data to identify similarities and differences (Charmaz, 2014).

Theoretical coding is the final level of coding and involves identifying the relationships between categories so that they could be placed into a theoretical framework (Charmaz, 2014). Once categories were well established, the principal investigator returned to the transcripts to determine how these categories related to each other across participants. She used a table in Microsoft Word™ to track how each participant moved through the identified categories over time. She frequently presented this table to the expert in qualitative methods, and they engaged in discussion about the emerging theory until consensus was reached. Because theoretical coding is a highly interpretive

activity, the student's project team was also involved in this step of coding. Members of the student's project team read several interview transcripts, and the emerging theoretical framework was presented to them. Feedback was sought from the student's entire project team, so the final grounded theory reflected team consensus.

To maintain trustworthiness and credibility, the principal investigator implemented several strategies. First, several individuals were involved in the data analysis process so that the final product of the study was consistent with the data and reflected consensus among the student's entire project team (Charmaz, 2005). Theoretical memos were also used to keep an audit trail of thoughts and analytic decisions that were made throughout the coding process (Charmaz, 2005). While traditional member checking of the findings was not completed, the principal investigator did question participants later in the interviewing process about categories that were emerging based on interviews from early participants to determine if these categories also resonated with the later participants' experiences (Charmaz, 2005). Several members of the student's project team had worked with Latina young women in community and mental health settings, so they were able to weigh in on the practical utility of the framework and if it resonated with their experiences working with this population (Charmaz, 2005).

Results

Twenty-five Latina young women participated in the study. The mean age of participants was 16.8 years with a range of 13-20 years. Seventeen

participants were recruited from community settings, and 8 were recruited from a primary care clinic. Eight participants were first-generation immigrants, 15 were second-generation immigrants, and 2 were third-generation immigrants and beyond. On average, first-generation participants had spent 10.14 years in the US, ranging from 5-12 years. Consistent with the demographics of the local community, most participants were of Mexican origin (64%). Three participants identified as Puerto Rican, two participants were Salvadoran, one was Nicaraguan, one was Colombian, one was Venezuelan, one was Honduran, one was Tejano, and one was Cuban. Several participants indicated having origins in more than one country.

The interviews ranged from 42 minutes to 1 hour and 50 minutes in length. Participants were forthcoming about their experiences with depressive symptoms and were able to provide rich descriptions of the important events in their lives related to their depressive symptoms. Young adult participants in particular were able to describe their experiences during adolescence with a great deal of insight and perspective. The use of the timeline to review the details from earlier in the interview often facilitated the identification of new and more detailed information related to the events in the participants' lives. A few participants became tearful during the interview, but most participants remained calm and relaxed. The principal investigator followed the interview distress protocol to ensure participant safety on two occasions; one in which the participant expressed thoughts of self-harm, and one in which there was an abuse concern within the participant's home.

Overview of the Framework

The theoretical framework (Figure 4.1) is comprised of a core psychosocial problem that was labeled Being Overburdened and Becoming Depressed and a psychosocial process that was labeled Getting a Grip on my Depression. Getting a Grip on my Depression is comprised of five phases that were labeled as follows: (1) hiding my depression; (2) keeping my depression under control; (3) having my depression revealed (4) skirting treatment for my depression; and (5) deciding to move on from my depression. Each phase is influenced by three social groups: the Latino family, the peer group, and mainstream authorities.

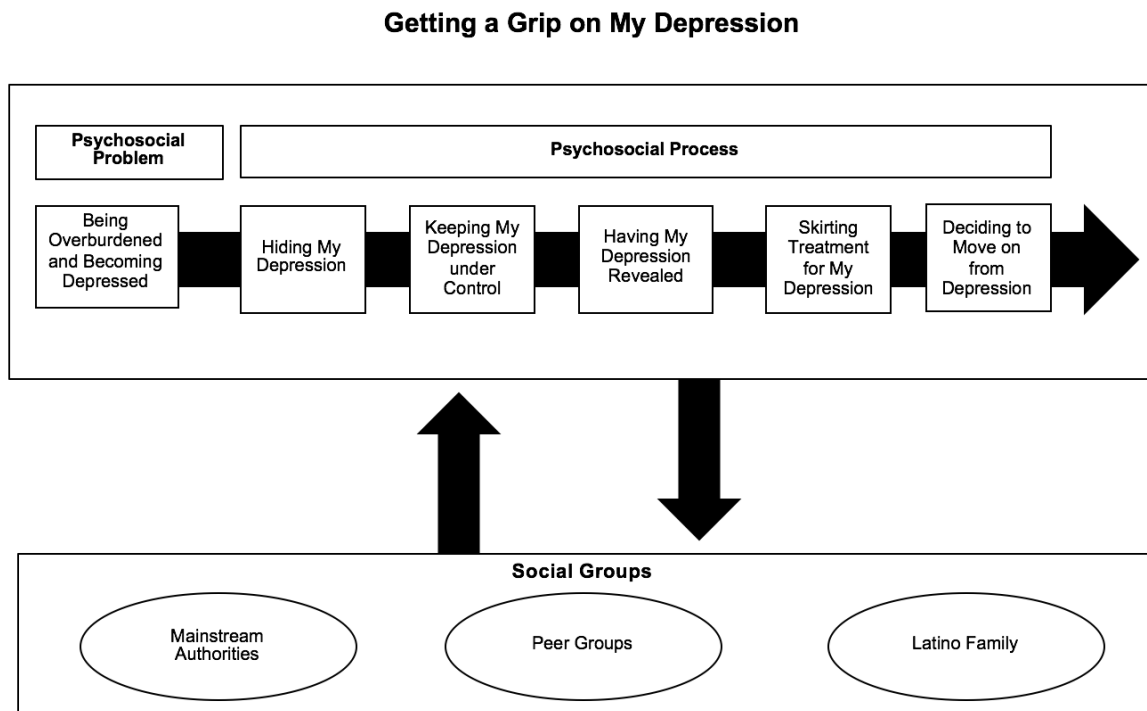


Figure 4.1. *Getting a Grip on My Depression Framework*

The framework is a conceptual rendering of common ways in which the participants discussed *Getting a Grip on my Depression*, but it is important to note that not every participant experienced all phases in the order they are presented. Some participants experienced only a few of the phases, some experienced two phases simultaneously, and some reverted to earlier phases when faced with new adversities. To describe the framework, I first discuss the three social groups that influenced the participants' experiences. I then describe the psychosocial problem *Being Overburdened and Becoming Depressed* that represented the central challenge identified by the participants. A discussion of the psychosocial process *Getting a Grip on my Depression*, and the five phases of the process follows. In discussing each phase, the evolving role played by each social group is addressed when applicable. Throughout the description of the framework, each finding is exemplified with examples and verbatim quotes drawn from the interviews.

Social Groups

Three social groups figured predominantly in the narratives of the participants and influenced their experiences with depression. The Latino family included individuals within the participants' nuclear family as well as extended family members such as "tias" and "tios" (aunts and uncles) and grandparents. Peer groups included individuals in the participants' schools or local communities who were in their age group such as friends or classmates. Mainstream authorities included adults in healthcare, educational, and government systems, most of whom were Caucasian. The role that these groups played in the

participants' experiences of depression evolved over time. Although persons in the three social groups provided help and support for the participants at various points throughout the process, the influences of these groups and the messages they gave to the participants about depression often conflicted, which created additional tension for the participants.

Psychosocial Problem: *Being Overburdened and Becoming Depressed*

The participants shared a common problem of being overburdened by a variety of stressors that they believed contributed to the development of their depressive symptoms. The participants were stressed because “a lot of things were going on” in their lives, and a variety of stressors “compounded” to contribute to the development of depression. One participant described the weight of all the stressful experiences in her life: “I feel like we’re [Latinas] carrying so much more.” The stressors that participants experienced often stemmed from their relationships with their Latino family, their peer groups, and mainstream authorities.

Participants felt burdened by family pressures that stemmed from their being an adolescent in a Hispanic family. Because many of the participants' parents immigrated to the US to give their children better economic opportunities, participants experienced much pressure to be the “best of the best” at school, make their family proud, and not to let their parents down. On top of expectations to succeed academically, many participants felt saddled with family responsibilities such as caring for siblings because their parents, often first-generation immigrants, had to work long hours to make ends meet in the US.

Participants also experienced conflict with their parents because parents retained traditional values from their home countries that conflicted with norms for adolescent autonomy in the US. As females, some felt that their parents were “overprotective,” not allowing them to go out with friends or have boyfriends, and this resulted in the participants feeling frustrated or angry with their parents. Many of the participants in this study also experienced deep sadness after being separated from family members due to economic circumstances, divorce, death, or deportation. Some thought that it was especially difficult to lose family as a Latina because of the emphasis on family connectedness and closeness in their culture.

Many participants discussed stressors in their relationships with peers. While most experienced many typical adolescent universal stressors, such as bullying and “rumors going around” school, some experienced discrimination as Latinas. A few were told by classmates to “go back [to their native country]” or that “[you] don’t belong here.” Others just felt “weird” or “different” from their Caucasian and AA peers.

Participants interactions with the mainstream authorities in their lives also contributed to stress. One of the most pronounced stressors for participants was the fear of deportation of themselves or their family members due to increased deportation activity in the US after the election of Donald Trump. Participants were “very scared” that they or their family members would be deported. Some also felt hopeless in the face of deportation, wondering what they would do if their parents were “kicked out” of the US and realizing that there was very little

that they could do to control outcomes surrounding deportation. Many participants were burdened with the knowledge that the US was not “good” to minorities and that they would have to be more prepared and work harder than their Caucasian peers to get ahead in the US. Other participants were stressed by their school systems that did not seem to support or protect them and other minority students.

Participants connected these multiple stressors to feelings of distress. They often felt sad, upset, or numb in response to events in their lives. Others had “panic attacks” or “explosions” of emotions. In addition to depressive symptoms, many participants engaged in disordered eating and self-harm behaviors. In reflecting on their experiences, participants recognized that these behaviors were manifestations of underlying depression. One participant who suffered from anorexia stated, “Depression was probably the root of it [anorexia], but at the time, like I said, I wasn’t aware of any of that.” Because participants connected a variety of mental health struggles back to depression, the examples that are provided below refer to both typical symptoms of depression as well as other mental health challenges such as self-harm, eating disorders, and anxiety. While participants recognized that these feelings and behaviors were not normal, most did not label their feelings as depression initially. One participant whose depression was not identified until young adulthood stated, “I just thought I was sensitive. I thought I just cried all of the time for whatever. ... I never acknowledged the word depression. I didn’t acknowledge that my past would affect me.” In response to emerging symptoms of depression, they moved into an

overarching psychosocial process that was labeled *Getting a Grip on My Depression*.

Psychosocial Process: *Getting a Grip on My Depression*

Getting a Grip on My Depression represents the core psychosocial process that represented participants' responses to *Being Overburdened and Becoming Depressed*. The common expression getting a grip means taking control of one's emotions or behaviors (Cambridge Dictionary, n.d.). This phrase was chosen to represent the core psychosocial process as the participants' responses to *Being Overburdened and Becoming Depressed* were highlighted by attempts to maintain control of their feelings of depression in the context of the social groups in which they were embedded. The participants frequently worked to "get their stuff together" and fought to "handle" their depression as best as they could. The phrase getting a grip also situates the capacity to control one's emotions or behaviors within the individual. The participants in this study most often assumed personal responsibility for controlling their depression rather than seeking help from others. The phrase getting a grip also implies an active process. Participants were actively "dealing" with their emotions, "figuring out" how to manage their depression, and "working" on getting better.

Hiding my depression. The first phase of *Getting a Grip on My Depression* was labeled as hiding my depression because the participants initially struggled to keep their depression to themselves. In this phase, they recognized they were experiencing problems with their mental health but took

measures to conceal those problems from others. The participants were likely to hide their depression from their family, peers, and mainstream authorities.

Latino family. Most participants worked hard to ensure that family members, particularly their parents, were not aware of their depression. They attempted to hide their depression due to concerns about how their parents would react to their mental health struggles. In some cases, participants concealed their depression in order not to burden their parents. One participant stated, “I didn’t really want to be a burden...My living situation. We were lower middle class and just something I shouldn’t burden with them. ...They have other things to do, and they don’t need a daughter who’s going insane.” Participants knew that their immigrant parents were working tirelessly to provide them with a good life, and therefore the participants did not want to trouble their parents with another problem. Other participants received clear messages from their family members that depression was not a “real” problem and feared that parents would be dismissive of their experiences. Participants recognized that their parents, who were often first-generation immigrants, had overcome a great deal of adversity to immigrate to the US. Parents would often compare their challenges in immigrating to the US to what they considered to be the minor challenges experienced by their children. One participant remembered her father saying, “You’re over here worrying about simple little things. You’re sad about simple little things, where people in my country, they don’t even have clean water in my country.” Parents often dismissed participants as being “over dramatic,” being “immature,” “making it [a problem] up,” or “wanting attention.” One participant

stated, “They [parents] definitely knew I was depressed, and they knew that I was shy and lonely. ...I think they knew, but they just didn’t want to make it too real.” Due to parents not wanting to address the depression and participants wanting to hide it, the participants’ mental health struggles typically went unaddressed during this phase.

Peer groups. Participants also frequently hid their depression from peers. Those who did open up to their friends often experienced negative consequences because their friends later betrayed their confidence. One participant stated, “I don't really trust a lot of people because every time I say something to them, they like go and tell other people. ...I feel like they're just gonna leave and tell other people about...my private life.” Due to betrayals of confidence, participants learned that they could not trust others and chose to keep their mental health struggles a secret. Similar to concerns that participants had about their parents’ reactions to depression, some participants also thought that they would disappoint their friends if they were to talk about their depression. One participant stated, “I wouldn’t tell my friends because I knew that they would be disappointed, and it would make me even more sad...” Other participants did not want to burden their friends. One participant explained, “I felt like it was a burden honestly. Depression is a burden. No one should have to deal with it... It was kind of hard to tell my friends.”

Mainstream authorities. In interactions with mainstream authorities, especially healthcare and school professionals, participants often explicitly lied to conceal their depression. For example, many participants lied when they were

given depression screening questionnaires at primary care visits. One participant described such an instance: “I would lie at those question things. I’d be like, ‘Yes, I’m feeling so much better. I feel like I don’t want to cut myself or hurt anyone.’ I’d just lie about it because I didn’t want to be questioned.” Several participants were also approached by teachers or guidance counselors when they noticed something might be wrong with the participants. In these cases, participants also lied to hide their problems. A participant who struggled with both depression and anorexia stated, “My guidance counselor had pulled me aside a few times. ‘Oh, you know you’re getting really thin. Is everything okay?’... I’d just be like, ‘Yeah, like I’m chilling.’ A lot of lying.” Participants believed that these professionals would have to tell their parents about the depression and decided to lie to authorities so word about their depression did not get back to their parents.

Intersections of social group influences. The influences of these three social groups converged as the participants often did not share their depression with peers or authorities to ensure that their parents did not find out about it. The following exemplar illustrates how a participant interacted with peers and mainstream authorities with an eye toward keeping her parents from becoming aware of her depression:

Interviewer: In relation to your depression, was there any time that you felt like someone broke your trust and it really hurt you?

Participant: Not really but I was always kind of afraid of that sort of thing. It’s mostly what kept me from talking to too many people about it besides my friends. I know my friends couldn’t talk to my mom, but if I went and talked to a counselor about it there would be a risk, and I would also sense some sort of risk of it coming back [to mom] and confidentiality being broken... Talking to friends was always an option but just not a doctor.

Keeping my depression under control. The second phase of *Getting a Grip on My Depression* was labeled as *keeping my depression under control* because participants took many measures to “handle” their depression and keep it from spiraling out of their control while they were still hiding it from others. They participated in activities such as sports, art, dance, and writing as a means to express emotions and “get out of their head.” They also found ways to “escape” from their distress by reading, watching TV, or playing games online. Some participants would sleep – or take what one participant called “depression naps” - in order to shut down their brains when their emotions and thoughts were getting out of hand. Some participants attempted to involve family, peers, and mainstream authorities in their efforts to control their depression. While some did receive help from these three groups, their assistance was often undermined in a variety of ways.

Latino family. While participants most often tried to control their depression on their own, some did make attempts to involve their parents, but these attempts often did not prove helpful. Unlike in the prior phase, participants did talk with parents about problems going on in their lives, such as "drama" with friends at school or family problems, but they did not frame these problems as depression. In this phase, participants tested their parents' reactions to topics related to mental illness. One participant described an encounter in which her friend, who was also Latina, provided suggestions for talking to parents about depression:

She said, “Maybe just bring it up someday and see what happens. Don’t say, ‘I am depressed.’ Don’t say, ‘I think I am depressed.’ Just

say, 'Hey, what do you think about depression?'" And so I did that at one point, and that's when they [parents] were saying, "I think sometimes people just make it up for attention."

In some cases, attempts that participants made to control their depression were undermined by their parents. Some parents inadvertently restricted strategies that participants were using to control their depressive symptoms, and participants attributed this to their parents' traditional values. One participant explained, "That was one of my coping things, listening to music, but they'd [parents] be like, 'No, no, no, you can't listen to that music in my house. This is a house of God'." Another participant who used reading to escape from the chaos in her life experienced conflict with her father when she wanted to stay up late to read: "I remember he [dad] would come in and turn off all the lights and tell me I couldn't read anymore because it was 4:00 in the morning...we had several fish tanks and I'd go under fish tank lights to read."

Peer groups. Peers were often involved in the participants' efforts to control their depression. Most notably, participants attempted to control their depression in conjunction with peers who were also suffering from depression, but these efforts could be destructive. Participants often learned about and were encouraged to participate in self-harm behaviors, especially cutting, by their female peers. One participant explained where she first heard about cutting: "Then another girl, she was also depressed. ...She just had all of these different thoughts and ideas that she would give me. She's like, 'I'm like this, and you should do it too [cutting].'" Others described self-harm as "contagious,"

"addictive," and "the new style" at school and used it as a way to relieve their negative feelings.

Some participants recognized that many methods that they used to keep their depression under control were not always advantageous. In particular, they realized that while hanging out with friends who were also depressed made them feel better at times, it was not the healthiest way to manage their depression. One participant explained, "My friends in high school had depression too.... Peoples' energies are very contagious, so you have to be a little bit careful to make sure you hang out with some people that don't want to die all of the time." Other participants found "escape" in being with their friends in ways that were not harmful. One participant explained, "Most of the time I was a lot happier being around them [friends], so I didn't really show as many symptoms, but when I was alone it was like, 'Ugh.'" For participants who were "unpopular" and did not have many friends at school, they turned to social media and online forums to find friends with whom they could talk.

Mainstream authorities. Mainstream authorities also played a role in how participants kept their depression under control. Similar to interactions with parents during this phase, some participants identified adults from the mainstream authority, such as teachers and pastors, with whom they would talk about their school and family problems. However, like with parents, they did not talk about these problems as depression. One participant described her close relationship with a youth pastor: "She sort of understands what I was going through, so I would be able to tell her stuff. ...Like sometimes, I was like really

struggling with science, and she was majoring in science." Participants also felt that being in the company of individuals such as teachers was a way to distract themselves from their depression.

Similar to what was experienced with the Latino family in this phase, participants also had coping strategies undermined by mainstream authorities. One participant stated, "I had a poetry club. ... I would write super dark stuff in that club. That actually got me sent to a guidance counselor. ...I stopped writing depressive stuff at that point because I got omitted from school." Another participant who had moved from Puerto Rico to the mainland US described how her depression management strategies were no longer available to her in her US high school:

I used to play soccer and I used to paint. However, when I got to the school or the high school where I went, these were kids that have been training intensively for years. ...So I would try out for something, and they would be like, "Oh no, you can't play, but you can go to this privately where you can pay to play" and stuff like that. ...So I guess the competitiveness kind of drove me away.

Intersections of social group influences. The influences of the three social groups converged in this phase primarily in regard to self-harm behaviors as peers encouraged these behaviors and parents and authorities were either not aware of them or alarmed by them. One participant recounted her experience with peer groups and mainstream authorities:

I was just this very thin person with a group of very thin people who all challenged each other to be thin. ...There were group chats where we all would list what we ate that day, yell at each other for eating, and through group chat shun each other for eating. ...Maybe because of my lack of... solid family figures like a mom and a dad caused me to find other outlets of solid, I don't know, control, I guess. So that would be drinking, anorexia, forming these mass

group chats of depressed children. ...I was extremely thin. That was probably my thinnest when she [guidance counselor] would call me in and be like, "Hey, are you eating?" ... A lot of my friends who were in the group with me, their parents started finding out, and a lot of them were hospitalized or taken out of school. They were like, "Oh you have an anorexic support group within your school."... It was just a challenge and a game and lose weight, and "Oh my family life sucks but I have this sense of control here."

Having my depression revealed. The third phase of *Getting a Grip on My Depression* was labeled as *having my depression revealed* because at some point in time, participants' depression was revealed to others either intentionally or inadvertently. During this phase, important individuals in the participants' lives realized that "something was up." Other participants decided that it was time to reveal their depression when they had "enough of it."

Latino family. The Latino family played a large role in participants' depression being revealed. Unlike in prior phases where parents realized something was wrong with their child and minimized the situation, there was a recognition by some parents during this phase that something was very concerning about their child's mental health. Many participants were caught by their parents self-harming or attempting suicide, and, at this point, the parents quickly realized that they needed to "take action." One participant stated, "I hurt myself, and then I was in the restroom, and then my mom went to the restroom, and I couldn't open the door. She opened, and she saw me.... she took me to the hospital." Other participants were questioned about their mental health when parents noticed extreme changes in the participants' moods and behavior. One participant described, "It was just a big explosion of me just crying and yelling, and that's when my mom said, 'We're going to get you help. This is a lot bigger

than something you can do by yourself.” Other participants did volunteer information about their mental health problems to their parents when they decided it was time to “confront” their depression, but they took care to “tone” down their feelings as to not alarm their parents. One participant stated, “I didn’t tell her [mom] I was suicidal. I was just like, ‘Hey, I’m thinking about trying medication. I’m not really feeling too well lately.’”

Peer groups. Some participants revealed their depression to friends who also suffered from depression. One participant stated, “My friend was feeling sad...and so I told her, ‘Hey, I feel the same way. I have similar thoughts,’ and we just kind of went back and forth, and we talked about what we feel.” These participants found it helpful to have peers who appreciated what it was really like to be depressed. One participant said, “It’s good [to have depressed friends] because then you can kind of communicate with people who can understand you.” In some instances, friends did inform mainstream authorities about the participants’ struggles, and the authorities then alerted the participants’ parents, the outcome the participants had wished to avoid. One participant recounted:

I’m really sad. So I told one of my friends that, and he thought I was going to kill myself because of how I talked about it. So then he told the school. ...I was called down to this health office where these mentors and counselors are like, “Oh are you dying? Are you suicidal? We have to call your parents if you feel this way.”

Mainstream authorities. Many authorities, especially healthcare providers, did eventually learn of the participants depression. The participants displayed behaviors that exposed their depression, revealed it on an assessment form, or intentionally disclosed it. For example, several providers notice changes

in the participants' weight, signaling underlying mental health concerns. One participant who had been struggling with bulimia said,

I came to [the doctor] and see that I was losing a lot of weight so fast, and then...she asked me if I was doing something bad. So I was like, "No," and she was like, "Are you sure?"...[the doctor] was like, "I feel like this is more depression or something, your feeling that is making you do this."

Some participants who had been lying to hide their depression from providers on assessment forms decided that it was time to "tell the truth." One participant described, "In previous years, they did the same screening, and I lied a lot...I kind of hid it for a really long time, so at that point, I was thinking maybe I should be honest and see what happens." Other participants volunteered concerns about their depression to a healthcare provider directly. One participant stated, "I was telling, because I just need some help. I don't know, how do I bring this up with the doctor? But I ended up telling my doctor about it [depression]."

Intersections between social group influences. The influences of these social groups, especially family and authorities, converged as the revelation of the participants' depression often revealed conflicts between these two groups. Most commonly, healthcare providers were advocating for participants' depression to be addressed while parents were more skeptical of labeling their child with a mental health problem. These conflicts created tension for the participants. One participant's story exemplifies how she negotiated this conflict:

Then I went to the doctor, and I was on the level of being like anemic. I was anemic. My mom was like, "No, that's not what she had," and the doctor was like, "No, she has it. She has depression. That's why she isn't eating and that's why she's really below weight." Mom was like, "No, she's not." That's when I heard the doctor say, "She has depression." ...I would come up with reasons

to go to the doctor. ...if I come up with different reasons to go to the doctor, maybe she [mom] will listen to her [doctor]. So I would just tell her [mom], "Oh, my stomach hurts" or "Oh, my head hurts all the time."... She [doctor] would always bring it [depression] up, and my mom would just like brush it off. ...Then my sophomore year...that's when the doctor really kind of... "You know, I'm telling you this because she needs to [get treatment for depression]."... That's when my mom she was like crying about it, and she decided that I should go to therapy.

Skirting treatment for my depression. The fourth phase of *Getting a Grip on My Depression* was labeled as *skirting treatment for my depression* because while many participants did receive some form of mental health treatment, they typically used services inconsistently and transiently. Participants would often initiate treatment, but their services would be interrupted or discontinued prematurely for some reason. One participant described this situation: "Could I actually get help? Every time I would get close to help in some way, shape, or form, it got either messed up or cut off."

Latino family. The Latino family played a large role in the participants' skirting of mental health treatment. Many participants perceived their parents as not valuing mental health treatment and attributed this to stigma towards depression in the Latino/a culture. Some participants' parents were resistant to their children receiving any mental health services, whereas others were skeptical of medication but thought that talking with a therapist was acceptable. One participant explained, "My grandma and my dad's side doesn't really think taking medication or anything like that is good for young people. She would rather talk about it."

Once participants were involved in mental health treatment, their parents did not encourage follow through with it. One participant who was seeing a therapist stated, “So she [mom] used to make my appointments for me, and then it’s been about two months where I didn’t go, and then I was like, ‘What’s going on?’ ‘Oh, no, you’re fine now.’...I was not feeling fine.” The few parents who had themselves had been depressed and received treatment were the most likely to be supportive and proactive in getting treatment for the participants. One participant, whose mother had arranged a visit with a psychologist, stated, “She [mom] moved pretty fast, because she knows how bad it [depression] is.”

Peer groups. Peers were usually not very influential in whether most participants’ received treatment for depression. In a few instances, however, some friends encouraged treatment, but others discouraged it and thus contributed to the skirting of the treatment for depression. The following story reflects how a participant got conflicting messages from her friends about the value of treatment:

I had two best friends at the time – A and K. I called A and I was like, “Hey, I’m in the hospital, and they’re about to send me to the psych ward, and I don’t know how to get out of here. I don’t want to be here.” She was like, “You probably need to be there. Just tell them the truth. You need to get some help. It’ll be okay. I’ll see you in a week. Don’t even worry about it.” Then I called K, and she was like, “You need to get the fuck out. Don’t tell them anything. They never listen to you. They won’t let you leave.”

Mainstream authorities. Mainstream authorities, primarily healthcare providers, were important figures in participants’ skirting treatment for depression. Participants discontinued treatment for a variety of reasons, mainly because they objected to some aspect of it. Some felt “crazy” or like a

“psychopath” because they had to see a mental health provider. Many participants stopped taking their prescribed medication due to feeling “drained,” “blank,” and “zoned out.” Others disliked their therapist or therapy itself, referring to it with words like “sketchy” or “nonsense-based.” Many participants were concerned about a therapist revealing information to their parents. One participant said, “She [therapist] was forced to tell my parents that I was having issues...what’s the point in seeking help when I’m still a minor, and no matter who I go to they have to report it to my parents.” Several participants had been hospitalized for suicide attempts; these hospitalizations were “scary” and “terrifying,” and participants felt “trapped” on inpatient units. For all of these reasons, some participants stopped their treatment abruptly while others told their therapists what they wanted to hear in order to be released from treatment. One participant who was hospitalized for suicidal ideation explained, “I talked to this doctor, and he’s the one who determined if we were going to go home or if we had to stay longer. Most of us lied.”

In a few cases where mental health treatment was helpful, participants recognized that it was the trusting relationship that they had with their mental health provider that made a difference, and it was often not until young adulthood when participants felt that they could be truly honest with their mental health providers without the fear of their parents finding about their problems. One participant explained her trusting relationship with her therapist:

She wasn’t my mother, [who would] gossip it to my tia, or she wasn’t my sister, and she would just pat me on the back and say, “It’s okay.” She was just mine. ...She didn’t know all my friends that

I was talking about. ...She's here for me, and I can really tell her and hear what she's saying.

Some participants had interactions with guidance counselors at school in relation to their mental health problems, but these encounters did not have a significant impact on the trajectory of the participants' depression. One participant explained, "She [guidance counselor] would ask me if I was okay...So she kind of like checked in, but it wasn't anything really substantial."

Intersections between social group influences. The influences of the social groups, especially family and authorities, converged as the participants frequently experienced tension because these two groups were often at odds in regard to the value of treatment. One participant's story exemplifies this tension:

The doctor had given us pamphlets about depression and where to go and therapy and all that. My mom, she just took them away from my hand. I remember we were going out to the car, and she just ripped it in front of me. She's like, "You don't need this. This is just like one of your tantrums or whatever." That just made me really sad because I was like if they're telling you this why aren't you helping me...

Deciding to move on from depression. The fifth phase of *Getting a Grip on My Depression* was labeled as *deciding to move on from depression* because many participants made decisions at one point in time to take matters into their own hands and leave depression in the past. Participants told themselves "it was time to change," decided to start a new "chapter," and "got [their] stuff together." In moving on from their depression, some participants decided to make changes in their academic or living situation once they reached young adulthood. One participant stated, "The change from high school to college honestly saved my life. I could not have done another however many years of high school ever."

Others found a different perspective that allowed them to have a more positive outlook on life. One participant described her response to hearing a song in church: "In that song, it said that I could go through these hard things, so I decided that Him telling me I can go through this, that's when I decided to think more positive than the usual." Others began to practice self-management strategies that were sustainable solutions to their depression. One participant explained:

Swimming literally helped me so much. ...It was just so open, just a big body of water and then you're swimming in it. I just let off so much stress and then I just felt so good. ...You're dealing with yourself. You don't have another person telling you what to do. This is what you're comfortable with, and you just kind of feel better for yourself.

Latino family. Participants did not describe their families as being very influential in moving on from their depression. Some parents had come to realize that the participants' depression was a serious problem and became allies in their recovery. After being hospitalized for suicidal ideation, one participant described, "They've [parents] been more understanding...There's just been a lot of encouragement after that too. 'Yes, you're going to get better. We're going to help you.'" For most of the participants, however, leaving their depression behind was a turning point that they attributed to their own determination or growth rather than the support of their families.

Peer groups. Although peers did not play a major role in most participants' leaving their depression behind, some did have friends who prompted a change in the participants' life perspective. One participant described, "I remember he [friend] asked me why I stopped trying. ...Those words

stayed stuck in my head. I was like, 'Why stop trying? Why give up now?' So that's when I started improving, and it was just those words." Others had friends who were supportive of the participants' progress. One participant recounted a conversation with her friends: "I feel like you guys should know [that I have depression] because it is me'.... They [friends] were surprisingly supportive. So, I feel like if more people spoke up, they'd be surprised."

Mainstream authorities. Mainstream authorities also played a minimal part in most participants' moving on from depression, although some participants had mental health providers who cared about them and facilitated their efforts to overcome depression. One participant who had been let down by prior teachers and guidance counselors asserted, "She [psychologist] really cares, and she really is trying to help me. ...That actually made me change my mind a little that other people can actually care and that they could actually try to help you." Others described how they began to consider advice from their therapists and tried coping strategies that their therapists had suggested. These participants thus found therapy to be helpful with moving on from their depression. One participant described:

I did what they [therapists] told me to do. I started finding things, good hobbies. There's hard days though, for sure. There's going to be more hard days, but because I have these things under my belt, I have my little tools. I know what makes me feel better. I know how to handle certain things. ...I'm like why didn't I listen to them when I was in therapy. ...I think that as you get older, maybe there's a reason they're telling you to do this stuff.

Intersections between social group influences. The influences of all the social groups were minimized in this phase because the participants most

often depended on themselves to move on from depression. With some exceptions as described above, participants took control of their depression and attributed their recovery to intrapersonal factors. One participant stated:

I've done the best job of dealing with my mental health than anyone else has. No doctor or mental professional has really provided me any sort of assistance that's helped me out. I mainly just deal with it myself. ...I worked a lot on self-love. I've been working on self-love since I realized I hated myself, but now I'm at a point where I feel a lot better about myself. ...I've really had to help myself, and if I couldn't help myself, I don't know what I'd do. Really, I feel like all of that I've done by myself.

Discussion

The Latina participants in this study described complex processes through which they experienced, self-managed, and sought treatment for depressive symptoms. The development of their depressive symptoms was closely tied to a variety of stressors, some of which were attributable to typical adolescent development and some of which were attributable to cultural stressors or the current political climate in the US. What was most notable about their response to their depressive symptoms (*Getting a Grip on My Depression*) was that despite their close ties to their families, the importance they attached to their peer relationships, and the looming presence of mainstream authorities in their lives, their response to their depressive symptoms was large intrapersonal. Initially they kept their depression to themselves (*hiding my depression*) and coped with it largely on their own (*keeping my depression under control*). When the depression did become known (*having my depression revealed*), it was largely because accompanying mental health problems, such as disordered eating or self-destructive behaviors, became obvious to others. Most participants never

became well entrenched in a therapeutic relationship (*skirting treatment for my depression*) and ultimately assumed responsibility for their own well-being, often after an insight that it was up to them to leave their depression behind and move on with their lives (*moving on from depression*).

The study findings resonate with the results of prior research on the mental health of Latino/a adolescents. For example, the problem identified as *Being Overburdened and Becoming Depressed* is consistent with the findings of previous studies on the etiology of mental problems in this population. Other researchers have found relationships between discrimination, family pressures and conflicts, adult responsibilities, fears of deportation or separation from family members, especially in the current US political climate, and mental health concerns (Garcia & Lindgren, 2009; Lopez-Morales, 2008; Roche et al., 2018).

The five phases that constituted the process of *Getting a Grip on My Depression* also support prior study findings on adolescents' common responses to depression. Consistent with the phase *hiding my depression*, several studies have shown Latino/a, AA, and Caucasian adolescents initially chose to hide their depression from others due to fear of being judged (Al-Khattab, Oruche, Perkins, & Draucker, 2016; Cordel, Anker, & Bansa, 2016; Draucker, 2005a; Lopez-Morales, 2008). Just as the participants in the current study hid their depression so that they would not burden family members, Lopez-Morales (2008) reported that Latina adolescents hid their depression to maintain peace within their homes. Also consistent with study findings, AA and Caucasian adolescents in prior studies reported that adults often did not take adolescents' depression

seriously when symptoms begin to emerge (Al-Khattab et al., 2016; Draucker, 2005a).

A literature review found that problem avoidance and support seeking strategies were commonly used by adolescents to manage stress (Garcia, 2010). The avoidance strategies identified in the review were similar to study participants' use of various activities to distract themselves from their problems in the *taking control of my depression* phase, and the support strategies were similar to their efforts at finding comfort by spending time with others. A study of depression in AA adolescents revealed that these adolescents, like the Latina adolescents in the current study, participated in sports, clubs, and leisure activities; spent time with friends who also had mental health problems; and listened to music as a means to manage their depressive symptoms (Al-Khattab, 2016; Al-Khattab et al., 2016). Other studies have also found that adolescents who are depressed are drawn to peers who are also depressed (Kiuru, Burk, Laursen, Nurmi, & Salmela-Aro, 2012; van Zalk, Kerr, Branje, Stattin, & Meeus, 2010).

Adolescents in prior studies also described a variety of ways of *having my depression revealed*. These adolescents voluntarily disclosed their depressive symptoms (Al-Khattab et al., 2016), hinted at their depression to see how adults would react (Draucker, 2005a), and were confronted about their mental health by adults in their lives (Al-Khattab et al., 2016). In the Lopez-Morales (2008) study, Latino/a parents became aware of their daughters' depression only when their daughters had explosions of emotions.

The finding regarding participants' *skirting treatment for depression* has also been described in prior studies as adolescents in these studies discussed numerous pitfalls to receiving mental health services, such as being labeled as "crazy," being "pumped" with medication, fearing violations of confidentiality, and feeling misunderstood by the therapist (Draucker, 2005b). Like the participants in the current study, adolescents in other studies and their parents held negative beliefs about mental health treatment, and thus the adolescents did not engage fully in therapy (Draucker, 2005b) or convinced their therapist that they did not need treatment (Al-Khattab et al., 2016; Draucker, 2005b).

The study findings extend this body of research in several ways. While studies consistently demonstrate that adolescents hide their depression from adults, the Latina participants in this study went to particular lengths to hide their depression, including lying outright to primary care providers and school personnel. Study participants were especially invested in keeping their depression from their parents and related this in particular to their Latina heritage and unique challenges associated with being first- or second-generation immigrants. Thus, my findings clearly situate the phenomenon of hiding depression in a cultural context. Another finding that has not been well developed in the literature was that many of my participants experienced a distinct turning point when they made a decision to move on from depression and largely attributed their recovery from depression to their own insight and resilience. Finally, my framework captures complexity that has not been evident in prior models in so far as the influence of each of three social groups on each phase in

my framework is delineated. This framework is thus the first to contextualize a multi-phase process by which Latina adolescents respond to depressive symptoms in the context of the social groups in which they are embedded.

Limitations

The findings should be considered within the context of the limitations of the study. Young women who identify as Hispanic or Latina were the focus of this study. Hispanic and Latina are broad terms that describe individuals from many diverse backgrounds, and therefore I was not able to make conclusions about how Latinas of varying Latino/a sub-groups experience and respond to depressive symptoms. However, there are common cultural factors spanning different Latino/a subgroups that have contributed to the development of mental health problems for Latina adolescents (Goldston et al., 2008), indicating that this recruitment strategy may have been sufficient for the purpose of the study. This study is also limited by its inclusion of only those Latinas who are fluent in English, perhaps excluding those who may be more recent immigrants to the US and thus face different challenges than those participants in this study. Another limitation of this study is that the cross-sectional approach only allowed us to gather data about participants' experiences with depressive symptoms at one point in time. Young adults were included in the sample so that they could reflect on how their experiences with depressive symptoms evolved over time; however, these young adults may have experienced difficulties in recalling this information due to the passage of time. The use of self-report of depressive symptoms, instead of a retrospective diagnostic interview, is also a limitation of this study.

While all participants reported having experienced depressive symptoms as adolescents, and some had received a diagnosis of depression by a provider, it could not be determined if some participants experienced sub-syndromal symptoms of depression or would have had met diagnostic criteria for a depressive disorder according to DSM-V classification (American Psychiatric Association, 2013). A retrospective diagnostic interview would have also allowed us to explore how the severity, intensity, and duration of the depression, as well as the presence of other co-morbid conditions, affected the process of *Getting a Grip on My Depression*.

Research Implications

To further refine the framework presented here, I suggest a longitudinal study that would allow for a series of interviews with Latino/a adolescents and young adults that could capture nuanced changes in their experiences with depression over time. I recommend that such a study be conducted with a larger and more diverse sample, including Latino young men and individuals of varying Latino/a backgrounds and immigration statuses. This would allow examination of group differences on symptom experiences and treatment pathways. Due to the role that familial beliefs about depression played in this study, further research might include interviews with Latino/a family members to obtain their perspectives on the stressors faced by their adolescents and their points-of-view about depression and mental health services.

Clinical Implications

Because my findings indicate that Latina adolescents' experiences with the management of and treatment seeking for depressive symptoms are different from adolescents of other cultural backgrounds, healthcare providers need to take unique approaches when identifying and treating depression in this population (Hooper et al., 2016). While more research is warranted to support cultural adaptations to evidence-based mental health treatments for Latino/a adolescents (Hooper et al., 2016), experts have recommended several culturally-sensitive practices that healthcare providers can incorporate into evidence-based methods for assessing and treating depression in Latino/a adolescents. In providing culturally sensitive care, providers should first practice reflexivity by reflecting on their own cultural biases (Bernal et al., 2009; National Council of La Raza, 2016). Health services should be provided in the appropriate language and incorporate Latino/a cultural values such as *familismo* (family closeness), *personalismo* (personal relationships), and *respeto* (respect; Comas-Diaz, 2006; Davidson et al., 2015; Duarte-Vélez, Bernal, & Bonilla, 2010). Providers should also take into account how experiences with cultural stressors such as discrimination and acculturative stress have impacted the Latino/a adolescent (Bernal et al., 2009; National Council of La Raza, 2016). Some experts have also recommended using metaphors or cultural idioms, such as using *dichos* which are common proverbs and metaphors in the Latino/a culture, to guide the course of therapy (Bernal et al., 2009; Comas-Diaz, 2006). These modifications will likely

increase the desirability of mental health treatments for Latino/a adolescents and result in improved treatment engagement and mental health outcomes.

The findings of this study also reinforce the importance of confidential consultations between adolescent patients and primary care providers. Studies have demonstrated that adolescent patients are more likely to discuss mental health concerns with primary care providers when their parents are not present in the room (Gilbert, Rickert, & Aalsma, 2014; Gilbert et al., 2018). Latina adolescents may be less likely to hide or lie about their depression if primary care providers have private conversations with these patients. While parents may be instrumental in making their child's depression treatment successful, they may also act as barriers to adolescents receiving mental health services in some cases (Radovic et al., 2015). Primary care providers should be aware that they are not obligated to report the adolescent's depression to the parents if the adolescent is not in danger of hurting themselves or others (Shain & AAP Committee on Adolescence, 2016). However, based on many individual states' laws, parental consent is necessary to initiate treatment for adolescent depression (McNary, 2014). If the Latina adolescent is suffering from mild depression and is resistant to involving her parent in treatment, the primary care provider may provide brief supportive therapy for depression using a structured worksheet (American Academy of Family Physicians, n.d.) without having to involve parents in the process. When it is necessary to disclose the Latina adolescent's depression to parents, the primary care provider should be

transparent about the process and allow the adolescent to have as much control over the conversation as is appropriate.

The framework developed in this study can be used as a guide to springboard discussions with Latina adolescents about their mental health. Healthcare providers might pose questions to Latina adolescents based on the phases identified in the framework. For instance, one question that a provider might pose based on this framework is, “Some Latina teens hide their feelings of depression because they fear how their parents will react if they find out they are depressed. Is this something that you have worried about?” Questions such as these may assist providers in identifying Latina adolescents that are in the phase of hiding their depression. If the provider has determined that the adolescent is experiencing depressive symptoms, they might state, “Some Latina teens who feel depressed hang out with friends who are also depressed. Do you have other friends who are going through similar mental health struggles?” The response to this question might assist the provider in determining if the adolescent is involved in a friend group that may be promoting self-harm behaviors.

Many participants in my study saw a mental health provider at one point in time but were quickly turned off from mental health services due to the therapist or their approach. During the first encounter, the therapist should work to establish a trusting and authentic relationship with the Latina adolescent, otherwise they may terminate therapy prematurely. At the beginning of the therapy process, mental health providers should also assess adolescent and

family beliefs about mental illness and how those beliefs might influence adherence to treatment.

Conclusion

This study presents a framework that describes the process by which Latina adolescents experience, self-manage, and seek treatment for their depressive symptoms. Similar to other groups of adolescents, Latina adolescents hide their depression from others, engage in activities to distract themselves from their depression, and perceive many downsides to receiving mental health services. What was unique about Latina adolescents' experiences with depression is that they were largely intrapersonal. Despite the influences of the Latino family, peer groups, and mainstream authorities, Latina adolescents went to great lengths to keep other individuals from knowing about and intervening with their depression and largely moved on from depression on their own terms. Future research is needed to enhance the framework and explicate how the process of Getting a Grip on My Depression might vary across different groups of Latino/a adolescents. Healthcare providers can use the framework to broach mental health topics with Latina adolescents to more effectively identify those struggling with depressive symptoms, promote engagement in mental health treatment, and ultimately, improve their mental health outcomes.

CHAPTER 5

Introduction

The purpose of this dissertation was to describe how Latina adolescents experience, self-manage, and seek treatment for their depressive symptoms. The findings of this dissertation will be disseminated through three separate papers. Chapter 2, an integrative review of the literature, determined the cultural stressors that have been associated with depressive symptoms for Latino/a adolescents in previous research. Chapter 3 builds upon this work by examining the contemporary stressors that young Latinas are experiencing in a tumultuous sociopolitical climate in the US. Chapter 4 presents a theoretical framework that describes how these stressors contribute to depression in Latina adolescents and how they respond to their depression through a five-phase process called Getting a Grip on My Depression. This chapter contains a synthesis of the findings of the three papers, a connection of the findings to previous theory, a description of strengths and limitations of the dissertation study, and a summary of implications for research, clinical practice, and policy.

Synthesis of Findings

The findings of each of the three papers can be synthesized into three overarching key findings. These key findings are as follows:

Key Finding 1: The Latino/a family plays an important role in Latina adolescents' experiences with depressive symptoms.

In chapter 2, the integrative review of the literature revealed that conflict with family members regarding differences in cultural values was associated with

depressive symptoms for Latino/a adolescents across many studies. Confirming this finding, the results presented in chapter 3 showed that Latina young women believed that their parents' strict values and protective behavior towards their daughters, or their parents' absence from the home due to working long hours, contributed to the stress that the young women experienced. This finding from chapter 3 was expanded in chapter 4 with results that suggested that Latina adolescents' conflict with their family members contributed to the development of their depressive symptoms and influenced the management of their depression. Because they received messages from their families that depression was not a real problem in their culture, Latina adolescents went to great lengths to hide their depression from their parents. When Latina adolescents were referred to mental health treatment, the Latino/a family often acted as a barrier to Latina adolescents receiving services, due to suspicions about medication or doubting the value of therapy. Latina adolescents eventually decided to move on from depression on their own terms, and their families did not often play a significant role in this process.

Key Finding 2: Latina adolescents' experiences with depressive symptoms are influenced by their interactions with peers.

In chapter 2, the integrative review findings demonstrated that discrimination was the mostly widely studied factor shown to be associated with depressive symptoms for Latino/a adolescents. The results presented in chapter 3 confirmed that Latina young women are treated differently by their peers, and they experience incidents of discrimination, stereotyping, and microaggressions

that contributed to the stress they experienced. They also noted that incidents of discrimination seemed to have intensified since Donald Trump had been elected president of US. The results discussed in chapter 4 expanded these findings by demonstrating that Latina adolescents connected general and discrimination-related conflict with their peers to the emergence of their depressive symptoms. They relied on female peers who were also depressed in the self-management of their depressive symptoms. In many cases, Latina adolescents were encouraged by these friends to engage in self-harm. After reflecting on these friendships, Latina adolescents realized that being around these friends was not helpful in recovering from their depression.

Key Finding 3: Mainstream authorities impact Latina adolescents' experiences with depressive symptoms.

In chapter 2, the integrative review revealed that being received negatively by society-at-large was associated with depressive symptoms for Latino/a adolescents. In the study described in chapter 3, Latina young women described how being treated differently by adults in their lives and feeling like the US did not support immigrants and minorities contributed to the stress they experienced. In this study, Latina young women also described how the policies and rhetoric from mainstream government authorities surrounding immigration in the US contributed to their fears of deportation for themselves or their family members. Latina young women described how their fears of deportation had become more prominent since the election of Donald Trump. The study results highlighted in chapter 4 extend this finding by showing that Latina adolescents connected

cultural stressors from mainstream authorities to the formation of their depressive symptoms. Some mainstream authorities, such as healthcare providers and guidance counselors, identified Latina adolescents who were struggling with depression and tried to connect them to appropriate treatment. Latina adolescents, however, sometimes lied to these individuals to avoid having their depression exposed to their parents. Although many Latina adolescents were linked to mental health services, providers were often unsuccessful in making meaningful connections with Latina adolescents, ultimately leading to treatment disengagement and discontinuation.

Connection to Previous Theory

The findings of the current study also support previous theories that were described in chapter 1.

The findings of this study support many of the concepts and relationships outlined in the Transactional Model of Stress and Coping (Lazarus & Folkman, 1984). Latina adolescents attributed their depressive symptoms to the many stressful situations in their lives. Consistent with this theory, their perception of the demands of certain situations in their lives outweighed the resources they felt that they had to overcome those demands, and their coping methods for managing these stressors were not sufficient in protecting them from developing depressive symptoms. This was particularly salient for participants who were fearing deportation of themselves and others. Latina adolescents felt helpless in the face of these fears of deportation because they believed that they had little resources to control the outcomes surrounding deportation. This study also

demonstrated that once Latina adolescents realized they had agency and personal resources for overcoming their problems, they were able to channel this new-found insight into adaptive coping strategies that allowed them to move on from depression.

The current study also supports previous theories that describe the acculturation process for immigrant communities. In this study, Latina adolescents were drawn in two cultural directions that often came into conflict, the Latino/a culture of their families and the mainstream culture of peers and authorities. They grappled with how to respect the values of their parents' culture, while still fitting in with peers at school. These challenges align with what the Bicultural Theory of Acculturation (Berry, 1974) would describe as the intersection between assimilation, separation, and integration acculturation orientations. The findings of this study also support assertions of the Interactive Acculturation Model, which suggests that dialogue surrounding immigration on the national level can impact how immigrants are received on the individual level (Bourhis et al., 1997). Consistent with this model, Latina adolescents described how acts of discrimination and microaggressions had seemed to worsen since the campaign and election of Donald Trump, which has been hallmarked by hostile comments and actions towards immigrant communities in the US.

Strengths and Innovation

To my knowledge, this is the first study that examined in-depth how Latina adolescents' depressive symptoms and efforts to manage these symptoms unfolded over time. This study provided a nuanced picture of how experiencing

cultural stressors contributes to becoming depressed, how Latina adolescents self-manage their depressive symptoms, and how they seek and receive treatment for their depressive symptoms, all areas that have been unexplored in previous research. The community-based approach that was used in designing and carrying out the study was a strength of the study. One year prior to recruitment, I consulted with Latino/a community stakeholders who confirmed their support for my research questions and assisted me in developing my recruitment strategy. Through their endorsement of my research, I was able to establish credibility with my participants. Community stakeholders also suggested that I obtain a waiver of documentation of consent and assent for my participants in order to provide them with a greater level of comfort about sharing sensitive information and allay fears about how their information would be used, especially in relation to documentation status. I believe these protections allowed research participants to be more candid about their experiences with depressive symptoms during the qualitative interviews. Other strengths of the study included the recruitment of a sample of Latina young women who had experienced a broad range of depressive symptoms, the inclusion of young adults who could provide retrospective accounts of their experiences with depression and adolescents who could provide contemporaneous accounts of their depressive experiences, data collection procedures that yielded in-depth and rich interviews, and systematic data analysis procedures based on constructivist grounded theory principles.

Limitations

Limitations of this dissertation study as a whole include the following: 1) the examination of the experiences of Latinas in general without exploring differences based on Latino/a sub-groups and immigration statuses, and 2) the investigation of Latina adolescents' experiences with cultural stress and depressive symptoms in a cross-sectional manner. Limitations of the integrative review specifically were as follows: 1) Inconsistent definitions of cultural stressors, and 2) small numbers of articles examining some of the cultural stressors. Limitations for papers derived from the qualitative interviews (chapters 3 and 4) include: 1) Use of retrospective accounts from young adults which may be limited by the passage of time, and 2) lack of retrospective diagnostic interviews to confirm if participants experienced depressive symptoms that would meet criteria for a diagnosis of depression.

Research Implications

Given the limited information available on depression in Latina adolescents, more research is needed to inform the development of prevention strategies and intervention approaches for the population using a variety of qualitative, quantitative, and mixed methods approaches. To extend the work of my dissertation project, future research should include the following:

Research Implication 1: Further Development of the *Getting a Grip on My Depression* Framework

Future research could be conducted to further refine, advance, and test the *Getting a Grip on My Depression* framework. A follow-up study to my

dissertation study would need to include a larger, more diverse sample of Latino/a adolescents including young men, recent immigrants, those from different Latino/a sub-groups, and those formally diagnosed with depression. This study should follow these individuals longitudinally to explore the various treatment pathways that Latina adolescents take over time and determine which pathways result in the most optimal mental health outcomes.

Research Implication 2: Examination of Contemporary Cultural Stressors and Depressive Symptoms

Due to the anecdotal and growing empirical evidence that cultural stressors are intensifying for Latino/a youth in the current sociopolitical climate in the US, future research should examine how cultural stressors such as fears of deportation and discrimination are impacting the mental health of contemporary Latino/a youth. This research should include a large, diverse sample of Latino/a adolescents from across the US.

Clinical Implications

While more research needs to be conducted to further develop the framework and develop culturally relevant approaches to address depression in Latina adolescents, the findings of this study do support the following clinical implications for practitioners:

Clinical Implication 1: Practitioners working with Latina adolescents should provide safe spaces in which they can discuss cultural stressors.

Practitioners working with Latina adolescents in clinical and community settings should recognize the cultural stressors that Latina adolescents

experience and create safe spaces in which they can discuss these stressors. Practitioners can use the categories of cultural stressors identified in chapters 2 and 3 to initiate conversations with Latina adolescents about how these stressors might be affecting their everyday lives. Practitioners can also teach adaptive coping strategies to Latina adolescents (Garcia, Pintor, Vazquez, & Alvarez-Zumarraga, 2013) and promote communication between parents and adolescents (Perrino et al., 2014), especially in relation to the cultural stressors that Latina adolescents are facing. Practitioners should also be knowledgeable of local resources for Latino/a families fearing deportation and be prepared to provide this information when necessary. Practitioners should also consider developing parent training programs that would educate parents of Latina adolescents about the cultural stressors their children face and teach them how to discuss these stressors with their children.

Clinical Implication 2: Healthcare providers should address issues related to confidentiality for Latina adolescent patients in clinical settings.

Healthcare providers should be aware that Latina adolescents may not be answering questions about their mental health or responding to depression assessment forms truthfully because they desperately do not want their parents to know of their depression. Patient-provider discussions about confidentiality are essential to create a safe space in which adolescents can discuss their feelings of depression or other mental health concerns. Providers should allow adolescents to control the flow of information to their parents but be clear about conditions under which confidentiality would be broken – such as when

adolescents are of danger to self or others. Providers might begin discussions by talking with adolescents about their fears or reluctance to inform their family that they are depressed or experiencing emotional distress.

Clinical Implication 3: Mental health providers should incorporate culturally-sensitive adaptations into evidence-based treatments.

Mental health providers can incorporate Latino/a cultural values such as *familismo* (family closeness), *personalismo* (personal relationships), and *respeto* (respect) into evidence-based treatments for adolescent depression (Davidson et al., 2015; Duarte-Vélez et al., 2010). Mental health providers might consider involving the family at some point in some components of the adolescents' therapy to address family stressors contributing to the adolescent's depression. Mental health providers should also assess parent and adolescent beliefs about depression to determine if these beliefs may be barriers to engagement in mental health treatment. During the initial evaluation, mental health providers should build rapport with Latina adolescents by listening and showing interest in their stories without minimizing their experiences. Therapists should draw on best practices of psychotherapy such as demonstrating empathy and positive regard and building a strong alliance with the adolescent (Wampold, 2015). The framework presented in chapter 4 can be used as a springboard to initiate discussions about how Latina adolescents are responding to their depression and how the three social groups may be helping or hindering their recovery.

Public Policy Implications

Latina adolescents would benefit from US immigration policies that provide more expedient pathways to citizenship for immigrants and allow Latino/a immigrant families to remain together in the US. Fears of deportation contributed to the development of depressive symptoms for Latina adolescents. Policies that would allow immigrant families to remain together in the US would decrease these fears and likely improve mental health outcomes for Latina adolescents. More expedient pathways to citizenship would also open many educational and economic opportunities for immigrant families. Immigrant-friendly policies such as these can also change the context of how immigrants in the US are received in greater society and ultimately decrease individual experiences of discrimination.

Conclusion

Latina adolescents are more likely to experience depressive symptoms and less likely to receive mental health services for their depressive symptoms than their Caucasian peers. The findings of this study confirm that cultural stressors are one of the main drivers behind the health disparity of depressive symptoms in Latina adolescents, and several of these cultural stressors appear to be intensifying for Latina adolescents in the current US sociopolitical climate. While cultural stressors that contributed to Latina adolescents' depressive symptoms are highly interpersonal, their responses to these stressors and their depressive symptoms were mostly intrapersonal. They hid their depression from others, engaged in activities to keep their depression from getting out, skirted treatment for depression, and eventually decided to move on from depression by

relying on their own strengths. This process of experiencing, self-managing, and seeking treatment for depressive symptoms for Latina adolescents is unique from the documented experiences of adolescents of other cultural backgrounds. The findings of this study support the argument that cultural modifications to evidence-based mental health interventions are necessary to meet the needs of Latina adolescents, and practitioners who serve youth in community and clinical settings can use the findings of this study to inform strategies to prevent, identify, and treat depressive symptoms in Latina adolescents in a culturally sensitive manner.

APPENDICES

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Appendix A

Telephone Distress Screening Protocol

-This is Allison Stafford from the Indiana University School of Nursing. Thank you for your interest in our study. Do you have any questions about the study? (If yes, then answer questions. If no, then proceed).

-Could you please verify your name and phone number?

-I want to double check that you are eligible for the study. What is your age? Do you consider yourself Hispanic or Latina? Did you experience depressive symptoms while you were a teen? (If “no” to any, thank for time and interest in study. If “yes” to all 3, then proceed with screening.)

-Because talking about depressive symptoms can be sensitive and might bring up tough feelings, we are advising individuals who are experiencing a high level of stress or emotional distress not to participate at this time. Is it all right if we ask you some questions to determine if there is any reason you should not participate? (If she responds “no,” thank for time and interest. If answers “yes,” conduct screening interview.)

Screening Question	No	Yes	Follow-Up Questions	Caller's Response	Acute Emotional Distress (Y or N?)	Imminent Danger (Y or N?)
Are you experiencing a high level of stress or emotional distress?			<ol style="list-style-type: none"> 1. Tell me what you are experiencing? 2. Is it getting in the way of you doing things you need to do (school or work)? 3. Is it getting in the way of you taking care of yourself? 4. Have you been in the hospital recently for this? 			
Are you currently having thoughts of harming yourself?			<ol style="list-style-type: none"> 1. Tell me what thoughts you are having. 2. Do you intend to harm yourself? 3. How do you intend to harm yourself? 4. When do you intend to harm yourself? 5. Do you have the means to harm yourself? 			
Are you currently having thoughts of harming someone else?			<ol style="list-style-type: none"> 1. Tell me what thoughts you are having. 2. Do you intend to harm someone else? Who? 3. How do you intend to harm him/her/them? 4. When do you intend to harm him/her/them? 5. Do you have the means to harm him/her/them? 			

Actions for Screener

1. If answers to screening questions are all NO, then schedule an interview.
2. If participant's responses reflect **acute emotional distress, but not imminent danger**, take the following actions:
 - a. Do not schedule an interview.
 - b. Recommend that the caller contact her current mental health provider or a recommended mental health provider for follow up.
 - c. Indicate that, with the caller's permission, the principal investigator, under guidance of Dr. Draucker, will call her the next day to see if she is okay.
 - d. Notify Dr. Draucker of the results of the screening.
3. If participant's responses to additional screening questions reflect **imminent danger**:
 - a. Contact the local law authorities.
 - b. Indicate that, with the caller's permission, the principal investigator will call her the next day to see if she is okay.
 - c. Notify Dr. Draucker of the results of the screening immediately.

Appendix B
Demographic Sheets
Young Adult

What is your age? _____

What is your occupation? _____

If you are student, what is your year in school? _____

What is your Latino ethnic background?
(Mexican, Colombian, etc.;
Can list more than one) _____

- Generational Status:
(Check one)
- First (You were born outside the US)
 - Second (Your parent was born outside the US)
 - Third (A grandparent was born outside the US)
 - Fourth (A great-grandparent or beyond was born outside the US)
 - Don't Know

If you were born outside of the US, how many years have you lived here? _____

Do you have any children? Yes No

If yes, how many? _____

Adolescent Demographic Data Sheet

What is your age? _____

What is your grade level in school? _____

What school do you attend? _____

What is your Latino ethnic background?
(Mexican, Colombian, etc.;
Can list more than one) _____

- Generational Status:
(Check one)
- First (You were born outside the US)
 - Second (Your parent was born outside the US)
 - Third (A grandparent was born outside the US)
 - Fourth+ (A great-grandparent or beyond was born outside the US)
 - Don't Know

If you were born outside the US, how many years have you lived here? _____

Do you have any children? Yes No

If yes, how many? _____

Appendix C

Interview Guide

Hi, my name is Allison McCord, and I'm a registered nurse and PhD student at the Indiana University School of Nursing. I have been studying Spanish since I was in high school, and through my Spanish classes and nursing training, I became really interested in the specific health problems that the US Latino population faces. Right now, I am doing research to learn more about mental health problems for Latina adolescents.

Before we start the interview, tell me a little about yourself.

FOR COMMUNITY ADOLESCENTS ONLY: You were selected as a possible participant because of your score on a questionnaire that you took before the Your Life. Your Story. Latino Youth Summit program. Some of the problems described on the questionnaire may be associated with depressive symptoms, and your score on the questionnaire indicates that you are experiencing problems similar to those that are sometimes seen in adolescents who have depressive symptoms.

Do you consider yourself as having depressive symptoms?

- a. If yes, ask this.
 - i. Tell me more about your experience with depressive symptoms. (Note: Use the term "depressive symptoms" throughout the interview)
- b. If no, ask this.
 - i. You indicated on the questionnaire that certain problems have been bothering you recently. These problems might be related to your mood, sleeping and eating habits, or negative thoughts about yourself. Tell me more about what problems like these have been bothersome to you lately. (Note: Use the term "bothersome problems" or name the specific bothersome problem in the adolescent's words throughout the interview)

FOR OTHER GROUPS BEGIN HERE:

1. Tell me about the first time you knew you were experiencing depressive symptoms.
2. Tell me what was happening in your life at that time.
3. Tell me how you have been managing your depressive symptoms.
4. Tell me about the worst experience you have had trying to manage your depressive symptoms.
5. Tell me about a good experience you have had managing your depressive symptoms- like when something you did seemed to help.

6. Do you feel that being a Latina in the US has influenced your experience with your depressive symptoms? If so, tell me how your Latina ethnicity or culture has shaped your experience with your depressive symptoms.
7. Have you received help for your depressive symptoms (or bothersome problems) from others? For example, family, friends, teachers, religious leaders, healthcare providers, etc.
 - a. If so, tell me about the help that you got.
(Note: repeat this question for each individual from whom the participant received help.)
8. Did you ever go to a mental health professional, like a therapist, counselor, psychologist, or psychiatrist, for your depressive symptoms?
 - a. If so, tell me how you decided to go to a therapist.
 - b. Tell me how it was arranged for you see a therapist.
 - c. What did the therapist (counselor, etc.) do that was helpful?
 - d. What did the therapist (counselor, etc.) do that was not helpful?
(Note: repeat these questions for any mental health professional seen.)
9. Do you feel that your Latina ethnicity or culture has influenced your experience with receiving help from others for your depressive symptoms? If so, tell me how your Latina ethnicity or culture has shaped your experiences of receiving help from others for your depressive symptoms?
10. Is there anything else you would like to tell me about your experience with depressive symptoms?
11. Now, I would like to construct a timeline to include any major events you have experienced in regards to your depressive symptoms. For example, when you first noticed you were having depressive symptoms, times when the depressive symptoms got better or worse, experiences that have made your depressive symptoms better or worse. (Note: discuss each age/year of school)
12. I will use the same questions that I have asked you today to interview other Latina adolescents in the future. Are there any questions that I asked today that you did not like or made you uncomfortable? Are there any important questions that I did not ask today that you think I should ask in the future?

Appendix D

Research Interview and Distress Protocol

The following protocol outlines the actions of the researcher if, during the course of the interview, a participant exhibits acute distress or safety concerns- or imminent danger to self or others.

Indications of Distress during Interview	Follow-up Questions	Participant Behaviors/ Responses	Acute Emotional Distress (Y/N?)	Imminent Danger (Y/N?)
Indicate they are experiencing a high level of stress or emotional distress, OR exhibit behaviors suggestive that the interview is too stressful, such as uncontrolled crying, incoherent speech, indications of flashbacks, etc.	<ol style="list-style-type: none"> 1. Stop the interview. 2. Offer support and allow the participant time to regroup. 3. Address mental status. <ol style="list-style-type: none"> a. Tell me what thoughts you are having. b. Tell me what you are feeling right now. c. Do you feel you are able to go on about your day? d. Do you feel safe? (If NO, ask questions below) 4. Determine if the person is experiencing acute emotional distress beyond what would be normally expected in an interview about a sensitive topic. 			
Indicate they are thinking of hurting themselves	<ol style="list-style-type: none"> 1. Stop the interview. 2. Express concern and conduct a safety assessment. <ol style="list-style-type: none"> a. Tell me what thoughts you are having. b. Do you intend to harm yourself? c. How do you intend to harm yourself? d. When do you intend to harm yourself? e. Do you have the means to harm yourself? 3. Determine if the person is an imminent danger to self. 			
Indicate they are thinking of hurting others	<ol style="list-style-type: none"> 1. Stop the interview. 2. Express concern and conduct a safety assessment. <ol style="list-style-type: none"> a. Tell me what thoughts you are having. 			

	<p>b. Do you intend to harm someone else? Who?</p> <p>c. How do you intend to harm him/her/them?</p> <p>d. When do you intend to harm him/her/them?</p> <p>e. Do you have the means to harm him/her/them?</p> <p>3. Determine if the person is an imminent danger to others.</p>			
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1. If a participant's distress reflects an emotional response reflective of what would be expected in an interview about a sensitive topic, offer support and extend the opportunity to: (a) stop the interview; (b) regroup; (c) continue.

2. If participant's responses reflect **acute emotional distress beyond what would be expected**, take the following actions:

- a. Refer the participant to her primary care provider (if applicable), one of the recommended mental health providers (young adults from the community), or Dr. Patricia Garcia (adolescents from the community) for follow-up.
- b. Provide the participant with the number of a hospital emergency room and a crisis hotline. Encourage the participant to call the crisis hotline if she experiences increased distress in the hours/days following the interview.
- c. Indicate that interviewer, under the supervision of Dr. Draucker, will call her the next day to see if she is okay.
- d. Notify Dr. Draucker and Dr. Bigatti (for adolescents from the community) of the recommendations given to the participant.

3. If participant's is in imminent danger, take the following actions:

- a. Contact the local law authorities, unless arrangements can be made to take the participant to the emergency room by a family member.
- b. Notify Dr. Draucker and Dr. Bigatti (for adolescents from the community) of the results of actions taken.

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Zeiders, K. H., Umaña-Taylor, A. J., & Derlan, C. L. (2013). Trajectories of depressive symptoms and self-esteem in Latino youths: Examining the role of gender and perceived discrimination. *Developmental Psychology*, 49(5), 951-963. doi:10.1037/a002886

CURRICULUM VITAE

Allison McCord Stafford

Education

- Doctor of Philosophy in Clinical Nursing Science (Minor- Social and Behavioral Science), Indiana University, earned at IUPUI, Indianapolis, IN (2014-2018)
- Bachelor of Science in Nursing, Indiana University, earned at IUPUI, Indianapolis, IN (2009-2013)

Professional and Training Experience

- Program Facilitator, Leadership and Education in Adolescent Health, Indiana University School of Medicine, Indianapolis, IN (2017-2018)
- Predoctoral Fellow, Institutional Research Training Grant (T32): Training in Behavioral Nursing Research, Indiana University School of Nursing, Indianapolis, IN (2015-2018)
- Graduate Research Assistant, Writing to Improve Self-in- Relationships Study, Indiana University School of Nursing, Indianapolis, IN (2015-2018)
- Predoctoral Fellow, Leadership and Education in Adolescent Health, Indiana University School of Medicine, Indianapolis, IN (2016-2017)
- Graduate Teaching Assistant, Undergraduate Pharmacology, Indiana University School of Nursing, Indianapolis, IN (2015)
- Graduate Research Assistant, Right Weight Study, Indiana University School of Nursing, Indianapolis, IN (2014-2015)

- Patient Care Intern Indiana University Health, Indianapolis, IN (2012-2014)

Publications- Refereed

- Published
 - McCord, A.L., Draucker, C.B., & Bigatti, S.M. (In Press). Cultural stressors and depressive symptoms in Latino/a adolescents: An integrative review. *Journal of the American Psychiatric Nurses Association*. doi:10.1177/1078390318778885
 - Gilbert, A.L., McCord, A.L., Ouyang, F., Etter, D.J., Williams, B.L., Hall, J.A., Tu, W., Downs, S.M., & Aalsma, M.A. (2018). Characteristics associated with confidential consultation for adolescents in primary care. *Journal of Pediatrics*. doi:10.1016/j.jpeds.2018.02.044
 - Etter, D.J., McCord, A.L., Ouyang, F., Williams, R.L., Hall, J.A., Tu, W., Downs, S.M., & Aalsma, M.C. (2018). Suicide screening in primary care: Use of an electronic screener to assess suicidality and improve provider follow-up for adolescents. *Journal of Adolescent Health*, (62)2, 191-197. doi:10.1016/j.jadohealth.2017.08.026
 - McCord, A.L. (2017). Ethical considerations for involving Latina adolescents in mental health research. *Journal of Child and Adolescent Psychiatric Nursing*, 30(1), 47-53. doi: 10.1111/jcap.12170

- Draucker, C. B., Martsof, D. S., Crane, S., Romero, L., & McCord, A. L. (2017). Designing an internet intervention for emerging adults who experience troubled relationships. *Archives of Psychiatric Nursing*, 31(3), 296-301. doi:10.1016/j.apnu.2017.02.002
- Under Review
 - Stafford, A.M., Bigatti, S.M, & Draucker, C.B. (Under review). Cultural stressors perceived by young Latinas living in a tumultuous sociopolitical climate in the United States. Submitted to the *Hispanic Journal of Behavioral Sciences*.
 - Draucker, C.B., Martsof, D., Crane, S., McCord, A., Romero, L., & Al-Khattab, H. (Under review). A Feasibility Test of an Online Intervention to Prevention Dating Violence in Emerging Adults. *Archives of Psychiatric Nursing*.
- In Progress
 - McCord, A.L., Etter, D.J., Downs, S.M., & Aalsma, M.C. (In preparation). Natural course of adolescent depression treatment in the primary care setting.
 - McCord, A.L. & Draucker, C.B. (In preparation). Emerging adult women's views of self in intimate partner relationships that are troubled.
 - McCord, A.L., Draucker, C.B., Bigatti, S.M., Oruche, U., & Aalsma, M.C. (In preparation). A grounded theory describing how Latina

adolescents experience, self-manage, and seek mental health services for their depressive symptoms.

Conference Presentations

- International
 - A. M. Stafford, C.B. Draucker, & S.M. Bigatti. (2018). Cultural Stressors Described by Latina Young Women Living in a Tumultuous Sociopolitical Climate. Poster to be presented at the Sigma Theta Tau International Nursing Congress, Melbourne, Australia. (abstract accepted)
 - A. McCord. (2018). Common Patterns in Latina Adolescents' Experiences of Depressive Symptoms, Poster to be presented at the International Society for Psychiatric Mental-Health Nurses Conference, Tempe, AZ.
 - A.L. McCord, & C.B. Draucker. (2018). Common Themes in the Stories Young Adult Women Write about Their Troubled Relationships, Poster to be presented at the International Society for Psychiatric Mental-Health Nurses Conference, Tempe, AZ.
 - A. McCord. (2017). Culturally-based stressors and depressive symptoms in Hispanic adolescents: An integrative review, Poster presentation, Sigma Theta Tau International Nursing Congress, Dublin, Ireland.

- National

- A.L. McCord, D.J. Etter, S.M. Downs, & M.C. Aalsma. (2018). Natural Course of Adolescent Depression Treatment in the Primary Care Setting, Poster to be presented at the Society for Adolescent Health and Medicine Conference, Seattle, WA.
- A.L. McCord, & C.B. Draucker. (2018). Common Themes in the Stories Young Adult Women Write about Their Troubled Relationships, Poster to be presented at the Society for Adolescent Health and Medicine Conference, Seattle, WA.
- C.B. Draucker, D.S. Martsolf, S. Crane, L. Romero, & A. McCord. (2016). Use of the Internet Intervention Model to design an internet-based psychotherapeutic intervention for emerging adults at risk for dating violence, Podium Presentation, Council for the Advancement of Nursing Science State of the Science Congress, Washington, DC.
- A. McCord. (2016). Culturally-based stressors and depressive symptoms in Hispanic adolescents: An integrative review, Poster Presentation, Council for the Advancement of Nursing Science State of the Science Congress, Washington, DC.

- Regional

- A. McCord. (2014). Breakfast consumption habits and barriers of preadolescent females, Poster Presentation, Midwest Nursing Research Society Conference, St. Louis, MO.

- Local
 - A. McCord. (2016). Culturally-based stressors and depressive symptoms in Hispanic adolescents: An integrative review, Poster Presentation, Maternal and Child Health Poster Day, IU School of Medicine, Indianapolis, IN, April 15, 2016.
 - A. McCord. (2013). Breakfast consumption habits and barriers of preadolescent females, Poster Presentation, Indiana University Health Nursing Research Conference, Indianapolis, IN.
 - A. McCord. (2013). Breakfast consumption habits and barriers of preadolescent females, Poster Presentation, Indiana University Undergraduate Research Conference, Bloomington, IN.

Grants and Fellowships

- Principal Investigator, *The Unfolding of Depressive Symptoms, Disease Self-Management, and Treatment Utilization for Latina Adolescents*, American Psychiatric Nurses Association, \$1,540 (2017- 2018)
- Principal Investigator, *Common Patterns in Latina Adolescents' Experiences of Depressive Symptoms*, International Society for Psychiatric-Mental Health Nurses, \$1,500 (2017-2018)
- Fellow, Research Incentive Fellowship Grant, Indiana University School of Nursing, \$30,000 (2015-2018)
- Fellow, IUPUI University Fellowship, Indiana University School of Nursing, \$22,500 (2014-2015)

Professional Memberships

- American Psychiatric Nurses Association (2017-Present)
- International Society of Psychiatric-Mental Health Nurses (2016-Present)
- Council for the Advancement of Nursing Science (2016-2017)
- Midwest Nursing Research Society (2014-Present)
- Sigma Theta Tau International Nursing Honor Society (2013-Present)

Certifications and Licenses

- Registered Nurse, State of Indiana (2014- Present)

Honors and Awards

- Premiere 10 (Top 10 Graduate Students on Campus), Indiana University-Purdue University Indianapolis (Apr. 2018)
- Elite 50 (Top 50 Graduate Students on Campus), Indiana University-Purdue University Indianapolis (Apr. 2018)
- 2nd Place Research Poster Competition, International Society for Psychiatric-Mental Health Nurses Conference (Apr. 2018)
- Lee Fuller Award for Clinical Excellence in Care of the Mentally Ill, Indiana University School of Nursing (Apr. 2017)
- Rising Star of Research and Scholarship, Indiana University School of Nursing (Nov. 2017)
- Highest Academic Distinction Graduate, Indiana University School of Nursing (Dec. 2013)
- Elisabeth Grossman (Highest Nursing GPA) Award, Indiana University School of Nursing (Dec. 2013)

Volunteer Service

- Invited Speaker, Gamma Phi Omega Sorority Conference (Apr. 2018)
- Invited Speaker, Big Brothers Big Sisters of Central Indiana Training (Feb. 2018)
- Facilitator- Resiliency Building Sessions, Your Life. Your Story. Latino Youth Summit Summer Camp, Indianapolis, IN (June 2016; June 2017)
- Program Volunteer, Young Latina Project, Indianapolis, IN (Jan. 2017-May 2017)
- Poster Presentation Reviewer, International Society for Psychiatric-Mental Health Nurses Annual Conference (Mar. 2017)