A MIXED METHODS APPROACH TO RESILIENCE AND DEPRESSION IN LATINA WOMEN

By

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A DISSERTATION

Submitted to
Michigan State University
in partial fulfillment of the requirements
for the degree of

Human Development and Family Studies—Doctor of Philosophy

2016

ABSTRACT

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Depression is a prevalent condition worldwide and it affects women more than men (Ferrari et al., 2013). This trend is consistent in the United States (US) where women have almost twice (2.5 vs. 1.6) the rate of depression than men (Regier et al., 1993). Latina women follow this pattern; their rate of depression is almost twice that of males (Vega et al., 2004). Given that Latinas/os are the largest minority group in the U.S. (U.S. Census Bureau, 2010) and the critical role that mothers play in Latinos' family well-being, it is imperative to address this issue. Using an integrated family resilience framework, the Relational and Resilience Theory of Ethnic Family Systems and the *Familias Fuertes* (Strong Families), the current project seeks to understand the risk (e.g., poverty, discrimination) and protective factors (e.g., family cohesion, belief system) that contribute to the depression experiences of Latina women. These frameworks have not been empirically tested with Latinas in the context of mental health.

Using a mixed methods approach, this dissertation project examined the moderation effect of family resilience on the relationship between risk factors and depression. It also explored the role of family resilience in Latinas' depression. The dissertation used two data sources: a quantitative data from the National Latino Asian American Study (N=1421) and a qualitative sample (N=15) of semi-structured interviews. The quantitative analysis revealed that two of the three risk factors studied predicted depression: perceived discrimination and family cultural conflict both predicted depression in women but financial strain was not a significant predictor of depression. The two moderator variables, religion and family well-being did not

buffer the effect of discrimination and family cultural conflict on depression. The qualitative findings revealed five main risk factors: children's health, family conflict and stress, financial strain, gender oppression, and racism. Two protective or family resilience themes were identified in the qualitative data: family schema (i.e., children and motherhood and religion) and patterns of functioning (social support). Based on the results, research, theory and practice implications are discussed.

ACKNOWLEDGEMENTS

The completion of this dissertation is the product of incredible support, encouragement, and mentorship from many individuals that I would like to acknowledge and thank. My dissertation chair, Dr. Marsha Carolan and committee members—Dr. Barbara Ames, Dr. Deborah Johnson, and Dr. Daniel Veléz-Ortiz—have provided invaluable mentorship and guidance in my doctoral journey. I am grateful to have each of you in my committee; your advice and expertise strengthen my dissertation project.

Dr. Marsha Carolan, thank you for the mentoring, guidance, and support you have provided me. I learned how to apply and integrate family theories in your class. This skill was very valuable during comprehensive exams and during the dissertation process; this skill is now part of my research toolbox. Thank you for modeling feminist research in our research project and dissemination phase.

Dr. Ames, thank you for your expertise in family finances. As a result of your feedback during my dissertation proposal, I was able to ask the women I interviewed relevant questions about work and finances. Thank you for always supporting my professional development and for allowing me the opportunity to teach college-level courses.

Dr. Johnson, thank you for your critical feedback during COMPS. Your mentoring and feedback has helped me become a stronger researcher. Dr. Velez, thank you for your mixed methods guidance and for your expertise in mental health with Latinos. Thank you for challenging and encouraging me to think of the recruitment process when I proposed my dissertation. As a result, I used a screener form with a vignette, using the screener form

facilitated the recruitment process throughout data collection stage of my dissertation. Thank you for all the research opportunities you have provided and for always taking the time to mentor me.

I have been fortunate to have amazing colleagues and role models who have provided critical support, guidance, and encouragement. I would like to thank Dr. Rocio Escobar-Chew for the support and kindness that she has given me. My accountably and writing group, *safe haven* (our group's name) has played a key role in the progress and completion of my dissertation; thank you Dr. Nkiru Nnawulezi, Dr. Christina Campbell, and Ashlee Barnes, M.A. (doctor to be). I would also like to thank Dr. Mercedes Morales-Aleman and Dr. Sinead Young for encouraging me to complete the work that matters to me and for reminding me that exciting life stages await after my Ph.D. program. Lastly, I would like to thank two instrumental statisticians: thank you Dr. Ola Rostant for all your patience and statistical advice, and thank you Frank Lawrence for your statistical advice.

Two of the instrumental sources of support and motivation were the Alliance for Graduate Education and the Professoriate (AGEP) and the College Assistant Migrant Program (CAMP). The AGEP community not only provided exceptional research and professional development opportunities, but this community nourished and sustained me during some of the most difficult times of my graduate studies. I met Dr. Tony Nuñez through AGEP, and I am indebted to him for the support, understanding, and encouragement he provided. From the bottom of my heart, thank you Dr. Nuñez. I would also like to thank the CAMP program for the opportunity to work with first-generation freshman migrant students. My experience working with the CAMP program kept me grounded and motivated me to work and to mentor younger generations of Latino students.

I would also like to extend my gratitude to the department of Human Development and Family Studies and the Graduate School for their generous financial support.

Last but not least, I would like to thank my family. To my loving parents, Mr. David Camacho and Mrs. Berenice Camacho-Robles who instilled in me values and principles that have undoubtedly shaped my character. I learned from both of you to not settle, to take risks, to work hard, to be honest, and to remain humble. This Ph.D. is for you, and for the opportunities you did not have and the life experiences you were not able to pursue. When I doubted whether I belong in academia, I thought of you and all the sacrifices you made for us, your children. It is because you dared to dream and pushed us to pursue our dreams that your children have a brighter future. It is because of you both that I thrive. Thank you to all my siblings, Azucena Camacho Robles, Joel Camacho Robles, Salvador Camacho Robles, Mariela Camacho Robles, and Karla Camacho Robles for being part of my life.

I am immensely grateful for having had Quinton Vernard Spencer, my life partner and husband by my side throughout this long journey. I could not have made it to the finish line without your support. You provided me with strength when I was hanging by a thread. I know you believe you should receive an honorary Ph.D., but that's not possible at this time. Lastly, I would like to acknowledge my dog, Sunny. He has been with me throughout my graduate journey at Michigan State University. There were times in graduate school when Sunny was the closest living being, knowing this made me feel so much better.

TABLE OF CONTENTS

LIST OF TABLES

LIST OF FIGURES

CHAPTER 1: INTRODUCTION

Background

Depression is a prevalent condition worldwide and it affects women more than men (Ferrari et al., 2013). This trend is consistent in the United States (U.S.), as evidenced in the Epidemiological Catchment Area Study, one of the largest national studies of mental disorders, that found that women had almost twice (2.5 vs. 1.6) the rate of depression than men (Regier et al., 1993). Depression is also the third most prevalent mental disorder in the U.S. (Kessler, Chiu, Demler, & Walters, 2005; Regier et al., 1993).

Depression is a widespread and far-reaching public health concern causing the largest amount of non-fatal burden—accounting for 12% of all total years' people lived with a disability worldwide. It is also the fourth leading cause of disease burden (Üstün, Ayuso-Mateos, Chatterji, Mathers, & Murray, 2004). By 2020, the World Health Organization (WHO) estimates that depression will be the second cause of disability worldwide (World Health Organization, 2001). It is also very costly; the annual economic cost of depression in the U.S. is $53 billion (Greenberg, Stiglin, Finkelstein, & Berndt, 1993).

Depression affects some ethnic groups more than others. Although Latinas/os do not report higher rates of depression than Whites, depressed Latinas/os suffer more than Whites because of treatment barriers (Mendelson, Rehkopf, & Kubzansky, 2008). Structural treatment barriers include limited access to mental health services (McGuire, Alegría, Cook, Wells, & Zaslavsky, 2006) and lower quality health care (Young, Klap, Sherbourne, & Wells, 2001). Other barriers, such as contextual and sociocultural factors exacerbate mental health service underuse (M. Alegría, Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., ... & Meng, X. L. , 2008).

These disparities are more pronounced among Latina women whose rates of depression are almost twice that of Latino males (Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004). Given that Latinas/os are the largest minority group in the U. S. (Pew Hispanic Center, 2009; U.S. Census Bureau., 2003) and the critical role that mothers play in a family's well-being, it is imperative to examine this issue among Latina women.

Statement of the Problem

Although risk and protective factors contribute to Latinas' experiences of depression, empirical literature is limited. Latinas' social and contextual risk factors, which may be preventable, involve gender inequality, ethnic/cultural discrimination, low socioeconomic status or poverty, and immigration experiences (M. Alegría et al., 2008; Belle & Doucet, 2003; Bonilla-Silva, 2003; Cardoso & Thompson, 2010). The combination of these risk factors can also cause stressful experiences (Contrada et al., 2000; Flores et al., 2008), which can contribute to women's depression. Despite these many risk factors, a large proportion of women carry on with their lives and do not report high rates of depression (M. Alegría et al., 2007). It is likely that resilient characteristics may buffer the effects of risk factors on depression. However, the study of resilience mechanisms in the context of risk factors and depression for Latina women is nascent.

Theoretical Framework

A family resilience framework will be applied to understand the risk (e.g., poverty, discrimination) and protective factors (e.g., family cohesion, belief system) that contribute to the depression experiences of Latina women. Family resilience is a dynamic process by which families respond, adjust, and adapt to a crisis or overwhelming accumulation of stress (Patterson, 2002; Walsh, 2003). Family resilience originates from the stress and coping theory and family

strengths literature, with a historical focus on war and families (Hawley & DeHaan, 1996; H. I. McCubbin, McCubbin, & Thompson, 1993). The most recent theoretical developments in family resilience are: (1) the Relational and Resilience Theory of Ethnic Family Systems (R&RTEFS) (L. D. McCubbin & McCubbin, 2013) and (2) the *Familias Fuertes* (Strong Families) (Bermudez & Mancini, 2013)[1]. To study Latinas' depression, the proposed project integrates the two theories above.

Although these theories overlap, together they offer a more complete theory for understanding Latinas' depression. The R&RTEFS describes the processes and components of family resilience with a new focus on ethnic families and a new focus on the influence of community context. Although this theory incorporates family resilience research with ethnic minorities, it does not include key cultural aspects (e.g., values, beliefs, attitudes and practices) that are specific to a Latina/o's family. On the other hand, the *Familias Fuertes* framework incorporates specific resilience processes for Latinos/as. Despite lack of empirical support and application to mental health in these theories, in part because of their recent development, their adaptation to understanding Latinas' depression is innovative.

Study Design

This dissertation study integrates findings from two studies: (1) a nationally representative sample (N = 1,427) of Latina women who participated in a compressive epidemiological survey of mental disorder called the National Latino Asian American Study (NLAAS) and (2) a purposive qualitative sample (N = 15) of Latina women who were interviewed in person. The NLAAS assessed several risk factors (e.g., discrimination, SES,

[1] These theories will be explained in more detail in the literature review section.

acculturation, family conflict), 12-month depression, and several resilience-related constructs (e.g., family cohesion, religion). However, the NLAAS—given its comprehensive and psychiatric focus, did not measure other important risk factors for women, such as gender oppression and ethnic microaggression. It also did not include other measures relevant to Latinas/os family resilience (e.g., positive outlook, functioning); neither did it allow women to share their experiences of depression and resilience. The studies together provide a more complete understanding depression, sociocultural and contextual factors and resilience mechanisms.

Purpose Statement

The overall purpose of this mixed methods dissertation is to empirically test parts of the family resilience framework using two studies. For study one, I used a quantitative data set to examine the role between risk factors for depression and the potential moderation effect of family resilience constructs. Specifically, three risk factors—financial strain, perceived discrimination, and family conflict—were examined as predictors of past year major depression. Then, parts of the family resilience moderating mechanisms were explored. Specifically, family wellbeing and religion— were examined as moderators of the three risk factors and depression. For study two, I used a qualitative data set of interviews I conducted to further explore the topics of interest. In the qualitative analysis, I explored risk and resilience themes using a thematic analysis approach (Braun & Clarke, 2006). Using both studies allowed for a deeper understanding of how different risk and protective (family resilience) factors affect women's depression. Table 1 illustrates the constructs and measures that were examined in both the quantitative and the qualitative datasets.

Research Questions and Hypotheses

Quantitative Research Questions

Research Question 1: Do risk factors, such as social disadvantage (financial strain), racial/ethnic discrimination (perceived discrimination), and family stress (family cultural conflict) predict major depression in the last 12 months? *Hypothesis 1*: Women with more social disadvantage, in the form of financial strain will be more likely to report depression than women with lower levels of financial strain. *Hypothesis 2*: High perceived discrimination would predict of depression. Women who report perceived discrimination, compared to those who do not report perceived discrimination, will also report an episode of major depression in the last 12 months. *Hypothesis 3:* Family stress, in the form of family cultural conflict, will predict a major depression episode. Women who report high levels of family cultural conflict will be more likely than women who do not report high levels of family cultural conflict to report depression.

Research Question 2: Does family resilience, in the form of religion and family wellbeing, moderate the relationship between risk factors and depression? This is an exploratory question given that testing this question depends on the risk factors that significantly predict depression.

Hypothesis 1: Religion (family schema construct) will moderate the relationship between risk factors and depression such that depression will be more likely to occur among

1a. Women with low religion and more financial strain

1b. Women with low religion and high levels of discrimination

1c. Women with low levels of religion and high levels of family cultural conflict

Hypothesis 2. Family relational wellbeing will moderate the relationship between risk factors and depression such that depression will be more likely to occur among

1a. Women with low family relational wellbeing and more financial strain

1b. Women with low family relational wellbeing and high levels of discrimination

1c. Women with low levels of family relational wellbeing and high levels of family cultural conflict

Qualitative Research Questions

Research Question 3: What risk factors do women describe as salient to their depression experiences? How do different forms of discrimination, such as sexism and racial and ethnic microaggressions relate to depression?

Research Question 4: How do women describe experiencing family resilience related to depression? What aspects of the family resilience framework are present in women's experiences of depression?

Table 1. Constructs of Interest & Their Respective Measure

Constructs of Interest	**Quantitative Measure (NLAAS study)**	**Qualitative Questions (number corresponds to the interview guide)**
	Depression	
Depression	12-month Depression (1-item)	9. How many times would you say you have experienced depression in your life? 10. When you were going through these (depression) periods, can you describe how you felt?
	Risk Factors	
Social Disadvantage	Employment status (1 question) Financial strain (3 questions)	4. Are you currently employed? N/A (but this topic came up in the interviews)

Table 1 (cont'd)

Discrimination	Race/ethnic discrimination (3 questions)	8. Do you feel that you have been treated different, in a negative way, or that you have had fewer opportunities because you are a Latina?
Racial/ethnic Microaggression & gender based discrimination	N/A	7. Have you ever been treated different, in a negative way, because you are a woman? 8. Do you feel that you have been treated different, in a negative way, or that you have had fewer opportunities because you are a Latina?
Family Stress	Family Cultural Conflict (5 questions)	N/A (other salient family stressors were shared in the interviews)
	Family Resilience	
Family Schema	N/A	14. Were there any advice or sayings that helped you? 14a. is a follow up with specific focus on cultural values.
	Religion (1 questions)	N/A (women shared about their religiosity as a coping mechanism)
Family Patterns of Functioning		13. Did anyone help you when you experienced depression? a. Probe for emotional expression, communication and problem solving, and functioning
Family Relational Well-being	Family relational well-being (4 questions)	N/A

CHAPTER 2: LITERATURE REVIEW

Depression: A Multidimensional Disease

Depression is a complex and multidimensional disease that can directly or indirectly affect individuals, families, and societies. As a mental health condition, depression involves symptoms and behaviors that interfere with psychological wellness and functioning (National Institute of Mental Helath, 2011). Depression affects cognitive functions (e.g., difficulty with memory or concentration), emotions (e.g., feeling sad, guilty), and physical functions—such as fatigue and decreased appetite (Gotlib & Joormann, 2010). Depression is also characterized by genetic, cognitive, and neurobiological vulnerabilities (Boland & Keller, 2009; Hammen & Brennan, 2003). Addressing each of these is beyond the scope of this dissertation. However, any of these genetic, cognitive, or neurobiological factors coupled with social and contextual risk factors (e.g., poverty, discrimination) increase the chance of depression. Depression is a complex construct involving multiple risk factors and varying degrees of severity, impairment, and chronicity. As a result, measuring depression is challenging (Abramson & Alloy, 2006; Sullivan, Neale, & Kendler, 2000; Thase, 2009). Further, the limited research on ethnic minorities and depression hinders researchers' ability to understand risk and protective factors. Depression among Latina women is the focus of this dissertation, and although multiple factors contribute to depression, only some of the social, contextual, and family risk factors are emphasized in the following sections.

Latinas/os in the U.S.

Latinas/os mental health is a relevant research topic, given that they involve 15% of the U.S. population (U.S. Census Bureau., 2008), and it is estimated that by 2055 they will account for one fourth of the population (U.S. Census Bureau., 2008). Given the recent rise in growth,

Latinos are now dispersed throughout the U.S. including states that traditionally had few Latinos. These areas are known as Latino emerging communities (U.S. Census Bureau., 2000). For example, the state of Georgia is one of the six states in which the Latina/o population has doubled since the nineties (U.S. Census Bureau., 2000). Georgia typically has not had a high concentration of Latinas/os. Thus, Latinas/os—particularly immigrants—may not find the same supports and services that they would if they were in a state with a longer established Latino community.

Depression as a Mental Health Disparity

Depression as a health disparity is described first, then the rates of depression among Latinos/as are discussed. Depression is a mental health disparity for Latinos. (M. Alegría, Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., ... & Meng, X. L. , 2008; McGuire et al., 2006). The difference in access and quality of care between Latinos and Whites contributes to mental health disparities. Although mental health access and quality barriers impact all groups in the U.S., ethnic minority groups are affected the most (U.S. Department of Health and Human Services, 2001). Compared to Whites, Latinas/os have decreased access to mental health services (McGuire et al., 2006) and they are less likely to receive treatment (M. Alegría, Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., ... & Meng, X. L. , 2008). Even when Latina/o receive treatment, the quality of depression treatment is lower than Whites' (Young et al., 2001).

Latinas/os' access and use of mental health services is also affected by structural factors such as lack of health insurance, and financial constraints, as well as sociocultural and personal barriers, including disease and medication stigma, self-reliant attitudes, acculturation, and language barriers (Barrio et al., 2008; Cabassa & Zayas, 2007; Hansen & Cabassa, 2012). If

Latinas/os encounter systemic barriers and challenges in treating their mental health, who or what do they resort to when experiencing depression? Research shows that Latinas/os rely on their families, network and other informal sources (e.g., alternative healers, spirituality) when dealing with mental health conditions (Cabassa & Zayas, 2007).

Depression Rates Among Latinas/os

Despite recent efforts from a nationally representative and comprehensive psychiatric Latino Study, NLAAS, the literature on Latinos' rates of major depressive disorder and depressive symptoms[2] is limited. A meta-analysis comparing lifetime prevalence of depression between Latinos and Whites found no difference in prevalence between the groups (Mendelson et al., 2008). However, many Latinas/os do not endorse clinical criteria for depression but still report high rates of depressive symptoms (M. Alegría et al., 2008). Although no difference in depression rate has been reported between Latinos and Whites, the literature emphasizes the influence of nativity or immigration for Latinos.

The Immigrant Paradox

The immigrant paradox proposes that immigrant Latinos have better mental health than U.S. born Latinos (Burnam, Hough, Karno, Escobar, & Telles, 1987). There is some support for this paradox in the literature. However, it may not apply to all Latino subgroups equally (M. Alegría et al., 2008). The paradox has only been consistently observed across psychiatric disorders—depression and anxiety—for Mexicans (M. Alegría et al., 2008). Mexicans are also the group who has consistently reported lower rates of depression (M. Alegría et al., 2008; Grant et al.,

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[2] These are different measures of depression: major depressive disorder derives from the Diagnostic of Mental Disorder (DMS)-IV, and epidemiological measures such as the Center for Epidemiological Studies Depression Scale measure depressive symptoms.

2004; Vega et al., 2004). For instance, Vega et al. (2004) reported that Mexicans, who immigrated to the U.S., had approximately half the depression rates than those who were born in the U.S.

Both M. Alegría et al. (2007)[3] and M. Alegría et al. (2008) examined the Latino immigrant paradox using the same large and representative dataset: NLAAS. Both also they reported similar results. M. Alegría et al. (2008) stratified the ethnic subgroups by nativity status (immigrant vs. US-born), and found that Mexicans had lower depression rates than any other group. M. Alegría et al. (2007) also found support for the immigrant paradox—regarding depression—for Mexicans only, but this effect disappeared when risk and protective factors (e.g., immigration, acculturation, enculturation, family, social status, and contextual factors) were accounted for. Thus, it appears that social, contextual, and family factors also play an important role in the depression experiences of Latinas/os.

The Latina/o Paradox

Similar to the immigrant paradox, the Latino paradox has been proposed as a potential explanation for Latinas/os health outcomes in comparison to Whites. Overall, empirical support has been found for the Latino paradox regarding lifetime prevalence of major depressive disorder. A meta-analysis of 23 depression studies concluded that Latinas/os do not show higher lifetime rates of depression than Whites (Mendelson et al., 2008). Consistent with this, the largest psychiatric study on Latinas/os also found that Latinas/os, despite their risk (e.g., SES, education, immigration) of psychiatric disorders, compared to non-Latino Whites, reported lower

[3] They included the NLAAS dataset only. While M. Alegría et al. (2008) combined two of the largest psychiatric datasets representing Whites and Latinos, including NLAAS.

rates (15.4% vs. 22.3%, respectively) of lifetime psychiatric disorders including depression (M. Alegría et al., 2008). Perhaps the role of resilience may be implicated in Latinas/os rates of depression given that Latinas/os, in a context of risk factors, do not report higher depression rates than their White counterpart.

Latinas' Rates of Depression

Although Latinas/os do not report higher rates of depressive disorder than Whites (Mendelson et al., 2008), research suggests that women may be more vulnerable to depression than men. In fact, Latinas' depression rate has consistently been reported as almost twice that of their male counterparts (M. Alegría et al., 2007; Vega et al., 2004). In community studies, Latinas also report high levels of clinical depression (Heilemann, Lee, & Kury, 2002; Marsiglia, Kulis, Perez, & Bermudez-Parsai, 2011; Ornelas, Perreira, Beeber, & Maxwell, 2009). In two of these studies (with samples of 315 and 136) 50% of the women reported high levels of depressive symptoms (Heilemann et al., 2002; Marsiglia et al., 2011). As with the larger Latino group, empirical support exists for the immigrant paradox—as U.S. born Latinas report higher depression rates than their immigrant counterparts, who are likely to have been raised in their country of origin (Heilemann et al., 2002; Vega et al., 2004).

Risk Factors and Social Determinants of Depression

Both social determinants of mental health and risk factors can likely cause depression. Although risk factors have long been recognized, the social determinants of depression have only recently been emphasized (World Health Organization and the Calouste Gulbenkian Foundation, 2014). The World Health Organization (WHO) defines social determinants of health as "…the circumstances in which people are born, grow up, live, work, and age, and the systems put in place to deal with illness. These circumstances are in turn shaped by a wider set of forces:

economics, social policies, and politics" (World Health Organization Key Concepts, p. 1). Social determinants of mental health involve low socioeconomic position and gender (World Health Organization and the Calouste Gulbenkian Foundation, 2014). Thus, Latina women who are economically disadvantaged are likely at greater risk for depression.

This review acknowledges the importance of other risk factors such as personal characteristics (Aldao, Nolen-Hoeksema, & Schweizer, 2010; Tamres, Janicki, & Helgeson, 2002), trauma (Briere, Kaltman, & Green, 2008; Chemtob, Griffing, Tullberg, Roberts, & Ellis, 2011), immigration and acculturation (Driscoll & Torres, 2013; Rothe, Tzuang, & Pumariega, 2010; Suárez-Orozco, Yoshikawa, Teranishi, & Suárez-Orozco, 2011), and generational status (Zsembik & Fennell, 2005). However, a description of these risk factors was omitted in order to present a concise review of the literature, which focuses on the risk factors that will be empirically examined. The following three categories of risk factors relevant to Latinas' depression are the focus of this section: (1) social disadvantage, (2) social stress, and (3) family stressors.

Social Disadvantage

Social disadvantage is conceptualized as the lack of or limited economic and social resources conferred by education, occupation, income and the effects of financial strain and subjective social status (De Castro, Gee, & Takeuchi, 2010). Some of these components, such as education, occupation, and income are known indicators of socioeconomic status (SES); however, financial strain and subjective social status (e.g., an individual's perception of his/her social status) have gained recognition as important indicators of health for immigrants and minority groups (De Castro et al., 2010). Thus, social disadvantage encompasses a broader, and perhaps more relevant, set of socioeconomic factors that influence Latinas' mental health.

In the U. S. social disadvantage has contributed to Latinos' experiences as a marginalized group. This includes residence in unsafe neighborhoods, limited access to quality education, lower SES, lower graduation and education rates, and lower paying jobs (Bonilla-Silva, 2003; Cardoso & Thompson, 2010). In national representative surveys Latinas/os compared to Whites were more likely to be born outside of the U.S., and they reported lower levels of education and household income (M. Alegría et al., 2008).

Women are at higher risk for living in poverty and harsh living conditions, using welfare, which may result in depression (Belle & Doucet, 2003; Hays, 2003; L. Smith, Appio, & Cho, 2012). Latinas/os who were unemployed, perceived to have low social standing, and perceived low neighborhood safety, were at risk for 12-month depression (M. Alegría et al., 2007). Poverty and inequality have been linked to psychological distress among Latinos, which ultimately affect women's mental health (Belle & Doucet, 2003; Molina, Alegría, & Mahalingam, 2013; J. P. Smith, 2003). All these social disadvantage factors indicate that Latinas may possess limited human capital (e.g., education), social capital (e.g., networks, opportunities), and financial capital that may compromise their mental health.

Labor Statistics for Women

Overall, women's socioeconomic status is influenced by their labor and income opportunities. On average, women earn 83% of what their male counterparts earn in a full-time position (U.S. Bureau of Labor Statistics., 2015). In other words, on average men earn a lot more in pay than women. When income is reported for women in different ethic groups, Asian women earn the most among all women in other ethnic groups, including whites. Specifically, for Hispanic women, they earn 65% of what Asian women earn (U.S. Bureau of Labor Statistics., 2015). Educational attainment and occupation are important indicators of income.

In general, people with higher levels of education earn more than those who have less than a high school diploma. (U.S. Bureau of Labor Statistics., 2015). There are clear gender disparities by occupation; for instance, only 10% of women in professional occupations are employed in high-paying fields such as technology and engineering. Given these statistics, it can be deduced that women with limited education face a multiple disadvantages as a result of their gender and educational attainment.

Social Stress

Based on the stress theory, stigmatized identities such as ethnicity/race, gender, and socioeconomic status can create experiences and situations or risk factors that can turn into overwhelming or accumulated stressors. For instance, the ongoing coping efforts required in dealing with everyday discrimination can be considered chronic stress (Contrada et al., 2000; Flores et al., 2008). Although the relationship between discrimination-based stress and mental health outcomes is incongruent (Paradies, 2006; Pascoe & Smart Richman, 2009), experiencing microaggressions and discrimination results in stress. The stress comes from processing the incident (event, attack, or insult) and deciding how to respond or cope (Huber & Cueva, 2012; Pascoe & Smart Richman, 2009; Yosso, Smith, Ceja, & Solorzano, 2009). Stigma, discrimination, and microaggressions all have physical, emotional, and psychological consequences (Huber & Cueva, 2012; Lee & Ahn, 2012; Molina et al., 2013; Pascoe & Smart Richman, 2009; Yosso et al., 2009). Thus, discrimination and microaggression can be conceptualized as social stressors.

Discrimination

In this section, I will discuss the risk factors associated with both overt and covert discrimination (i.e., microaggressions and colorism), as it relates to race/ethnicity and gender.

Racism and discrimination have been associated with a range of health outcomes, including physiological (e.g., cardiovascular disease) and psychological (e.g., psychological distress) outcomes (T. N. Brown et al., 2000; Harrell, Hall, & Taliaferro, 2003; Pascoe & Smart Richman, 2009). A systematic review of 138 studies that examined the relationship between racism and both mental and physical health outcomes found limited evidence of the negative effects of racism on a person's mental health (Paradies, 2006). However, a meta-analysis of 143 studies found that perceived discrimination had a negative effect on both mental and physical health (Pascoe & Smart Richman, 2009). The results between these studies may differ, in part because their methodological approach is different, but also because Pascoe and Smart Richman (2009) included other forms of discrimination and not just racism.

Latinos are diverse, but as an ethnic minority group they share oppression experiences that affect their mental health (Guarnaccia et al., 2007). Ironically, for many Latinos, their experiences of anti-immigration and a sociopolitical hostile environment makes their American Dream of opportunities and success into a nightmare reality (Casanova, 2012; Guarnaccia et al., 2007). Language and phenotype are two additional sources of discrimination for Latinos (Bonilla-Silva, 2003; Parra‐Cardona, Bulock, Imig, Villarruel, & Gold, 2006). Discrimination consistently predicts depression among Latinas/os (M. Alegría et al., 2007; Torres & Ong, 2010).

Colorism and Microaggressions

Covert discrimination includes colorism (Burton, Bonilla‐Silva, Ray, Buckelew, & Hordge Freeman, 2010) color-blind racism (Bonilla-Silva, 2003), and microaggressions (Sue et al., 2007), which are all interrelated. Colorism refers to intragroup and intergroup racism or the privilege and advantages associated with lighter skin complexion (Burton et al., 2010), and its effects on both psychological and socioeconomic outcomes (Hochschild & Weaver, 2007).

Bonilla-Silva (2003) challenges the post-civil rights race discourse that racism has disappeared, and demonstrates how racial ideologies in the U.S. are tied to structural and power relations that result in tangible inequalities for people of color.

In a similar fashion other scholars have argued that racism has not declined, rather the ways in which racism is expressed and experienced has changed; this is known as racial microaggressions (Sue et al., 2007). "Racial microaggressions are brief and commonplace daily verbal, behavioral, or environmental indignities, whether intentional or unintentional that communicate hostile, derogatory, or negative racial slights and insults toward people of color" (Sue et al., 2007, p. 271). Regardless of how racism is expressed (overtly or through microaggressions) it affects those who experience it.

Gender Based Discrimination & Violence

Latina women's risk for depression can be exacerbated when considering women's intersecting socially oppressed identities such as gender and race/ethnicity (D. Brown, L, Griffin-Fennell, & White-Johnson, 2012). Gender based discrimination such as sexism and sexual harassment can affect any woman (Jackson & Newman, 2004). But women of color face a dual discrimination risk (Chisholm & Greene, 2008). Women's experiences of sex discrimination have been linked to depressive, anxious, and somatic symptoms (Klonoff, Landrine, & Campbell, 2000). Violence against women is rampant; in a U.S. population-based study, roughly 29% of women reported partner violence when they were intimate (Coker et al., 2002). Consistent empirical evidence supports the negative consequences of intimate partner violence on women's mental health (Bonomi et al., 2006; Caetano & Cunradi, 2003; Coker et al., 2002; Coker, Smith, Bethea, King, & McKeown, 2000; Lown & Vega, 2001; Mechanic, Weaver, & Resick, 2008).

Family Stressors

Family stressors as risk factors for Latinas' depression are described here after providing some context of the role of family in Latinos. Family life is salient for Latinas/os; however, this is not unique to Latinos. Nonetheless, researchers continue to focus on family life for Latinos evidenced by the research construct familismo/familism (e.g., Bermudez & Mancini, 2013; Cardoso & Thompson, 2010). *Familism* refers to family loyalty, harmony, interdependence, and cooperation (Marin & Marin, 1991). Given the importance of family among Latinas/os, research interest has emerged about the negative influence of family stress on depression (M. Alegría et al., 2007). Although this research is in its nascent stage, family stressors such as family burden (e.g., demands imposed by family) and family cultural conflict (e.g., intergenerational conflict in families) have been reported as predictors of depression among Latinas/os (M. Alegría et al., 2007).

Theoretical Framework: Resilience

Individual Resiliency

No concrete definition of resiliency—individual characteristics and internal processes—has been agreed upon, but all conceptualizations involve the ability to, or process of recovery or functioning in the face of adversity (e.g., Luthar, Cicchetti, & Becker, 2000; Masten et al., 1999). The study of resiliency originated in the psychopathology and development literature, which focuses on: (a) set of competencies, (b) coping strategies, and (c) psychological and developmental outcomes (Luthar et al., 2000; Masten et al., 1999). Thus, resiliency is conceptualized as risk and protective factors (Ungar, 2003).

Risks include drastic changes, events or crisis (e.g., a child with cancer, immigration) that would create demands and stressors above and beyond the individuals' capacity and resources

(Masten & Coatsworth, 1998; Masten et al., 1999; Schoon, 2006; Ungar, 2003). Protective factors refer to the internal, personal characteristics (e.g., independence, creativity, hardiness, coping style) that allow the person to adapt and function despite the risk factors (Masten et al., 1999; Schoon, 2006; Ungar, 2003). Three models have been proposed capturing the different ways risk and protective factors affect outcomes. The protection model describes resources interacting with risks to buffer the risks' effect on the outcome (a moderation effects model); in the cumulative model, resources have a positive and independent effect from risks; and in the challenge model the effects of the resources depend on the risk level, as low and moderate risk levels can elicit positive outcomes (Schoon, 2006).

Over the last couple decades, several attempts, from different angles, have been made to clarify, improve, and borrow concepts from the definition of resiliency. For instance, Hawley and DeHaan (1996) applied resiliency concepts, such as developmental transitions, risk and protective factors, and proposed a definition of family resilience with a focus on lifespan. On the other hand, Patterson (2002) attempted to clarify the difference between individual and family resilience. Yet, other researchers have proposed a refined definition of resiliency as a multidimensional construct responsive to the individual-environment interaction (Luthar et al., 2000; Ungar, 2008, 2011). The increased recognition of the influence of context including family, community, and culture bridges the gap between individual resiliency and family resilience.

Family Resilience

Family resilience is a dynamic process by which families respond, adjust and adapt to a crisis or overwhelming accumulation of stressors (Antonovsky & Sourani, 1988; Hawley & DeHaan, 1996; H. I. McCubbin et al., 1993; Patterson, 2002; Walsh, 2003). Family resilience originates

from the stress and coping theory and family strengths literature, with a historical focus on war and families (Hawley & DeHaan, 1996; H. I. McCubbin et al., 1993; Patterson, 2002). This created a shift in family research and family practice. It shifted from a pathological approach to a family strengths approach (H. I. McCubbin et al., 1993; Patterson, 2002; Walsh, 2003). Family resilience encompasses a plethora of family research topics and model developments.

Similar to individual resiliency, no family resilience definition has been agreed upon, but all family resilience definitions involve recovery, adapting, or functioning in the face of adversity (L. D. McCubbin & McCubbin, 2013; Walsh, 2006). Patterson (2002) noted that the lack of consensus about family resilience was, in part, because of differences in the two main uses and purposes of family resilience: in clinical settings, for practical purposes, resilience is defined as a trait; and in research, for knowledge production and theory development, resilience is defined as a process.

Walsh (2006), for instance, from a clinical perspective, identified three major family resilience's themes: (a) belief system, (b) organizational patterns, and (c) communication processes—including problem solving. Similarly, L. D. McCubbin and McCubbin (2013), from a theory perspective, also identified three major themes called system properties: (a) family schema, (b) patterns of functioning, and (c) relational well-being. Overall, there is a significant overlap between the concepts used by both family researcher and clinicians. This highlights family resilience's practical utility, one of the criterion for evaluating family theories (White & Klein, 2008).

Family Resilience's key concepts include: (a) family schema, (b) sense of coherence, (c) patterns of functioning, (d) resources, (e) communication, (d) relationships, and (e) adjustment and adaptation (e.g., H. I. McCubbin et al., 1993; L. D. McCubbin & McCubbin, 2013; Walsh,

2006). Family schema involves a family's shared values, goals, priorities, expectations and worldview, which serve to process and evaluate events and experiences (H. I. McCubbin et al., 1993; L. D. McCubbin & McCubbin, 2013). Sense of coherence involves comprehensibility (how much the situation makes sense cognitively), manageability (perceived resources to manage demands), and meaningfulness (how much life make sense emotionally) (Antonovsky & Sourani, 1988). Resources or family capabilities are described as the tangible and psychology resources and coping behaviors (Patterson, 2002).

Communication and relationships are at the heart of family resilience because of the importance of social support, problem solving, and power relations in families (Walsh, 2006). Adjustment, or the family's initial reactions and changes in response to the stressors or crisis, and adaptation, or the process or outcome of resilience in terms of desirable family functioning are integral concepts of family resilience (L. D. McCubbin & McCubbin, 2013; Patterson, 1988, 2002; Walsh, 2003, 2006). All of the above concepts of resilience reflect the intersection of family values, attitudes and behaviors.

Other important aspects of family resilience's conceptualization are its focus on the family unit and the family as a system. The family is seen as a system with different moving parts (e.g., different individuals and family dynamics), as a system the family is also embedded in the ecosystems (e.g., macrosystem) and as a result is influenced by sociocultural and contextual factors (Hawley & DeHaan, 1996; L. D. McCubbin & McCubbin, 2013; Patterson, 2002; Walsh, 2006). Family resilience considers the influence of temporal factors (e.g., timing of stressor, pileup of stressors), and development and lifespan on the family (Hawley & DeHaan, 1996; L. D. McCubbin & McCubbin, 2013; Patterson, 2002; Walsh, 2006). This is important because a family's stressors and resources, as well as their outcomes, are not static. Given the

importance of lifespan development and change over time, researchers have advocated for understanding resilience both short- and long term (Hawley & DeHaan, 1996).

Resilience in Ethnic Families

L. D. McCubbin and McCubbin (2013), integrated decades of research experience across nations and cultures, proposed the most recent family resilience theory that focuses on ethnic families. This theory is called the Relational and Resilience Theory of Ethnic Family Systems (R&RTEFS). The R&RTEFS defines families as active and dynamic with the ability to evolve, change and respond to structural, social and cultural influences (L. D. McCubbin & McCubbin, 2013). Ethnic family systems is defined as "… consisting of interdependent elements, and as collectives with ancestral origins, POF [patterns of functioning], having a collective identity and having responsibility to maintain their commitment to the family and to harmonious relationships with the neighborhood, community, society, and the world" (L. D. McCubbin & McCubbin, 2013, p. 178).

The R&RTEFS includes three interrelated family system properties: (1) family schema or family identity, (2) patterns of functioning (POF), and relational well-being (RWB). Family schema has been consistently conceptualized as in previous models, but now it highlights the importance of race and ethnicity for ethnic families. POF are the ways in which families interact to sustain and nurture family members; These patterns characterize families based on the adaptability and cohesiveness of the family (L. D. McCubbin & McCubbin, 2013). L. D. McCubbin and McCubbin (2013) reviewed five POF models and concluded that POF can be grouped in two clusters: (1) core system patterns such as flexibility, traditions and celebrations, and bonding, and (2) circumstances and context. RWB involves individual and collective notions of wellbeing with an emphasis on interpersonal relationships and harmony with nature.

Unlike previous iterations of family resilience, the R&RTEFS makes several critical contributions to family resilience: the integration and recognition of structural, social, and cultural factors; this is similar to recent developments in intersectionality theory (Anthias, 2013; Carastathis, 2013; Cho, Crenshaw, & McCall, 2013). Another contribution is the inclusion of ethnicity as a central construct, even L. D. McCubbin and McCubbin (2013) acknowledge that a well-grounded, accurate and sensitive conceptualization of ethnic families was overdue. This focus on ethnicity will provide some theoretical foundations to better understand the growing number of ethnic and multiethnic families in the U.S. The third contribution is the conceptualization of resilience as a system theory; this conceptualization better captures the complex social realities of modern families.

Although L. D. McCubbin and McCubbin (2013) have a long history of conducting research with ethnic families nationally and internationally, they do not seem to have experience working with Latinas/os. Their emphasis on culture and ethnicity are relevant for understanding Latina/o family resilience, but it may not be enough, given that Latinos share a unique historical and sociopolitical context in the U.S. Thus, the R&RTEFS needs to be culturally tailored for Latinas/os before it can be relevant and applicable.

Family Resilience Among Latinas/os

Resilience among Latinas/os has primarily been studied at the individual level with children and adolescents. However, some recent conceptualizations of Latinas/os' family resilience have been proposed, highlighting the interrelated influence of culture, community, individual, and family (Bermudez & Mancini, 2013; Cardoso & Thompson, 2010; Mogro-Wilson, 2011). Bermudez and Mancini (2013), drawing from both Walsh's clinical resilience work and Cardoso and Thompson (2010) worked on Latinos resilience, proposed a Latina/o

family resilience clinical framework, and called it *Familias Fuertes* (Strong Families). Their framework in addition to resembling the three systems proposed in the R&RTEFS model, also emphasizes Latina/o's cultural values and ethnicity. The three major themes or components in the *Familias Fuertes* framework are (1) belief systems—this is the family schema in the R&RTEFS model, (2) organizational patterns— the relational well-being in the R&RTEFS model, and (3) communication processes— the patterns of functioning in the R&RTEFS model. Since these themes are very similar in both frameworks, only the labels given in the R&RTEFS will be used.

Empirical Evidence: Depression & Family Resilience Among Latinas/os

The literature on adult Latinas' individual resiliency in relation to depression is scant; most of the literature focuses on Latina adolescents and school outcomes. However, some studies have reported internal or intrinsic assets such as self-mastery, life satisfaction, and a sense of optimism as individual resiliency factors protecting against depression among Latina adult women (Campbell, 2008; Heilemann et al., 2002; Marsiglia et al., 2011). Other Latina/o resiliency factors such as active coping (e.g., problem solving) and self-efficacy have also been explored in relation to depression (Driscoll & Torres, 2013; Torres, 2010; Torres & Rollock, 2007). Entrepreneurship, resourcefulness, creativity, and a desire for independence were resilient characteristics among Latina women facing hardships (Campbell, 2008).

The relationship between family resilience and adaptation has been studied more in the literature than the relationship between resilience and depression. For instance, familism, family cohesion, and family support are frequently studied among Latinas/os in the context of acculturation and family adaptation (e.g., Bacallao & Smokowski, 2007; Heilemann, Pieters, Kehoe, & Yang, 2011; Parra‐Cardona et al., 2006; Rodriguez, Mira, Paez, & Myers, 2007). A

handful of studies report family resilience including social support, familism, networks and community resources as beneficial for Latinas' mental health (Casanova, 2012; Jenkins & Cofresi, 1998; Marsiglia et al., 2011; Ornelas et al., 2009; Raffaelli, Tran, Wiley, Galarza‐Heras, & Lazarevic, 2012). Although these studies make important contributions to understanding the role of Latina's resilience and mental health, the overwhelming majority of the studies are qualitative.

Overall, the knowledge base is limited regarding Latinas' depression and their risk and protective factors. None of these studies found have empirically tested the relationships between Latina women's risk factors and depression and the moderating role of family resilience concepts. M. Alegría et al. (2007) examined the relationship between several risk and protective factors on psychiatric disorders including depression focusing on NLAAS Latino subgroup comparisons and immigration factors (the significant findings have reported in other parts of the review). They found no support for several of the risk (i.e., employment, income, education, and discrimination) and protective factors (i.e., enculturation, religion, and family support) regarding depression.

The present study focuses on similar risk and resilience constructs, which is what M. Alegría et al. (2007) studied, however, some of the measures are different. For instance, while M. Alegría et al. (2007) studied religion, their focus was on religious attendance. On the other hand, the present study examined the frequency of seeking comfort in religion when dealing with difficulties in life. Thus, both measures are related but they focus on different aspects of religion. The present study is innovative because it explores the moderating role of two family resilience constructs: (1) family schema measured through religion and (2) family wellbeing measured from a subscale of the Circumplex model.

Conceptual Model

Figure 1 depicts the conceptual model for the present study, illustrating risk and protective factors for depression in Latina women. For illustration purposes, this model is an oversimplification of the direct and moderating relationships among the constructs of interest—risk factors (e.g., financial strain, perceived discrimination, and family conflict), depression (past year major depressive episode), and family resilience (e., religion and family wellbeing). A moderator is a third variable that changes the relationship, in strength or direction, between a predictor variable (e.g., risk factor) and an outcome variable (e.g., depression) (Baron & Kenny, 1986).

Figure 1. Model of Risk and Resilience Factors for Depression

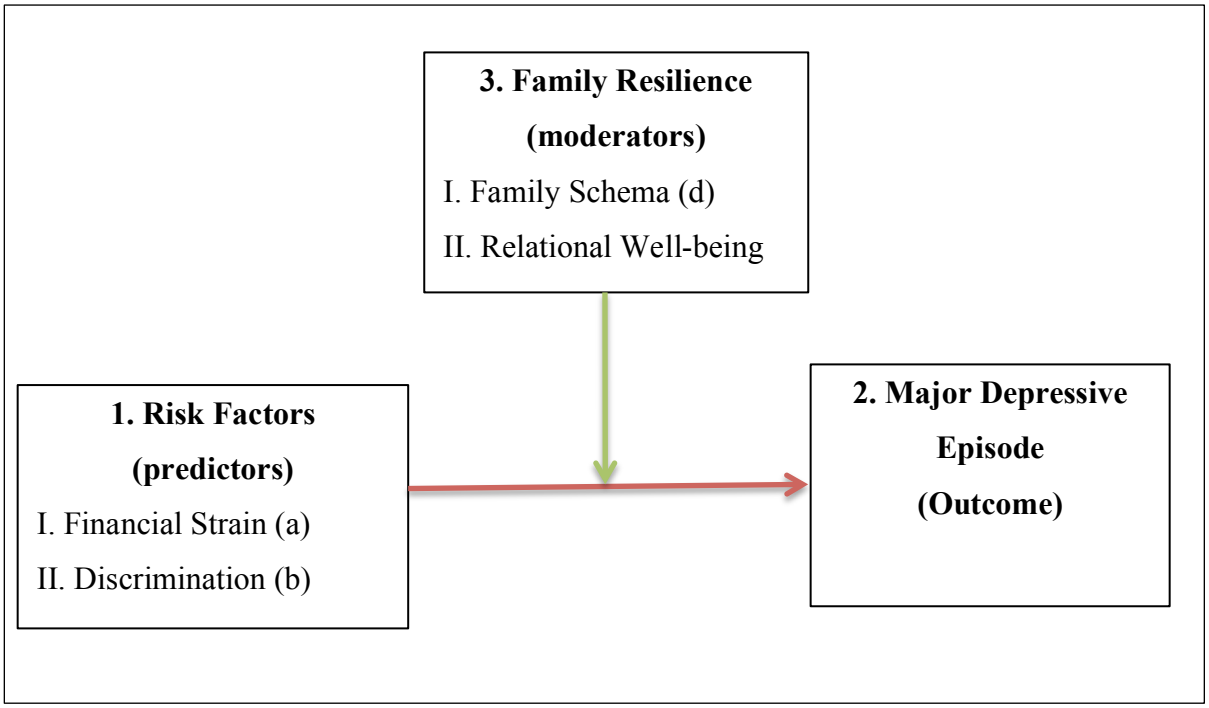


Figure 1 shows the family resilience model: risk and protective factors of depression. Box 1 illustrates the three risk factors and box 3 illustrates the two family resilience mechanisms.

In the model above, the red arrow between box 1 and box 2 represents the direct path or relationship between the risk factors and the outcome. In other words, it shows financial strain, perceived discrimination, and family conflict predicting depression. The green arrow intersecting the red arrow represents the potential moderation effects of family resilience on risk factors and depression. Specifically, this means that religion and family well-being, separately, would interact with each of the risk factors. For instance, if moderation is present, this would indicate that women with high levels of perceived discrimination and low levels of family well-being would be more likely to report past year major depression than women with high levels of discrimination and high levels of family well-being.

Risk and Protective Factors in the Model

Based on the literature, it is expected that the social disadvantage (measured through financial strain, letter a), social stress (measured through discrimination, letter b), and family stress (measured with family cultural conflict, letter c) will be significant predictors of a major depressive episode in the previous year.

The components in the R&RTEFS model and the *Familias Fuertes* framework, and the empirical evidence from the specific measures that make up the three family resilience categories, inform which measures to include under each resilience category. Family schema category (letter d) in the form of religious comfort and family relational well-being category (letter e) will be explored as potential moderators of the aforementioned relationship between risk factors and depression.

Literature Review Summary & Research Questions

Summary of Literature

Latinas/os are one of the fastest growing ethnic groups in the U.S. (U.S. Census Bureau., 2008). Although Latinas/os do not report higher rates of depression than Whites, they face more challenges and barriers in treating their mental health conditions (M. Alegría, Chatterji, P., Wells, K., Cao, Z., Chen, C. N., Takeuchi, D., ... & Meng, X. L. , 2008; Mendelson et al., 2008). As a result of these structural treatment barriers, Latinas/os may rely on informal sources such as family, friends, and community network. Perhaps these informal supports contribute to Latinas/os potential resilience (Ornelas & Perreira, 2011), as evidenced by Latinas/os' lower rates of depression compared to Whites (M. Alegría et al., 2008). Depression is influenced by a set of social risk factors (e.g., contextual, social, and familial); however, the literature has not delineated the influence of different risk factors. Abundant literature supports the negative influence between depression and the three categories of risk factors—social disadvantage, discrimination, and family stress (e.g., M. Alegría et al., 2007; Belle & Doucet, 2003). The literature also supports the positive role of family resilience-related variables such as family cohesion, social support, and familism (e.g., Casanova, 2012; Ornelas & Perreira, 2011). Overall, the literature informs the relationship between risk factors and depression and family resilience and depression; however, the research regarding these topics for Latina women is scarce. More studies are also needed, which explores the buffering (moderating) effect of family resilience on risk factors and depression among Latinas. The current study aims to further the knowledge base on Latinas and their depression. Specifically, the following research questions will be examined.

Quantitative Research Questions

Research Question 1: Do risk factors, such as social disadvantage (financial strain), racial/ethnic discrimination (perceived discrimination), and family stress (family cultural conflict) predict major depression in the last 12 months? *Hypothesis 1*: Women with more social disadvantage, in the form of financial strain will be more likely to report depression than women with lower levels of financial strain. *Hypothesis 2*: High perceived discrimination would predict of depression. Women who report perceived discrimination, compared to those who do not report perceived discrimination, will also report an episode of major depression in the last 12 months. *Hypothesis 3:* Family stress, in the form of family cultural conflict, will predict a major depression episode. Women who report high levels of family cultural conflict will be more likely than women who do not report high levels of family cultural conflict to report depression.

Research Question 2: Does family resilience, in the form of religion and family wellbeing, moderate the relationship between risk factors and depression? This is an exploratory question given that testing this question depends on the risk factors that significantly predict depression.

Hypothesis 1: Religion (family schema construct) will moderate the relationship between risk factors and depression such that depression will be more likely to occur among

1a. Women with low religion and more financial strain

1b. Women with low religion and high levels of discrimination

1c. Women with low levels of religion and high levels of family cultural conflict

Hypothesis 2. Family relational wellbeing will moderate the relationship between risk factors and depression such that depression will be more likely to occur among

1a. Women with low family relational wellbeing and more financial strain

1b. Women with low family relational wellbeing and high levels of discrimination

1c. Women with low levels of family relational wellbeing and high levels of family cultural conflict

Qualitative Research Questions

Research Question 3: What risk factors do women describe as salient to their depression experiences? How do different forms of discrimination, such as sexism and racial and ethnic microaggressions relate to depression?

Research Question 4: How do women describe experiencing family resilience related to depression? What aspects of the family resilience framework are present in women's experiences of depression?

CHAPTER 3: METHOD

Mixed Methods Design

A mixed methods approach is best suited to answer the study's research questions. Given the scarcity of literature investigating Latinas' depression risk factors and family resilience, addressing both quantitative and qualitative questions in the same study will enhance the mono-method approaches typically used to study resilience and depression. I was able to test relationships among the variables with the quantitative data, and describe some of the cultural (and ethnic) resilience and depression nuances with the qualitative analysis. Thus, using both methods allowed for a deeper understanding of the phenomenon than if only one approach had been used (Onwuegbuzie & Leech, 2006). Both the quantitative and qualitative data analysis approaches are explained in later sections.

The quantitative study along with the theoretical framework directed the focus of the dissertation while the qualitative study expanded the understanding of risk and resilience factors. Although the NLAAS included several risk factors (e.g., social position, discrimination) related to depression, it did not measure other important risk factors for depression such as microaggressions, sex-based discrimination, and violence. The NLAAS also included some constructs (e.g., family cohesion, religion) related to family resilience, but it did not measure other important family resilience constructs like traditions, celebration, and family support related to depression. The sampling design is considered a multilevel relationship because the two sets of samples are obtained from different populations (Collins, Onwuegbuzie, & Jiao, 2006). Both samples are described in detail in their respective sections below. The sample for the quantitative component was obtained from the NLAAS, a comprehensive and nationally representative study of Latinos mental health conditions. This study has a sample size of 2,554

Latino respondents, of which 1,427 are women. The qualitative sample was obtained through a purposive sampling technique; 15 women who had experienced depression were interviewed at a community based mental health organization. After I collected the qualitative data, I started preparing the data sets for analysis. The qualitative analysis (study 2) was carried out first and the quantitative analysis (study 1) followed. As recommended by Creswell, Clark, Gutmann, and Hanson (2003) integration of the two methods will occur during the interpretation phase of the study, specifically in the discussion chapter.

Figure 2. Mixed Methods Concurrent Design

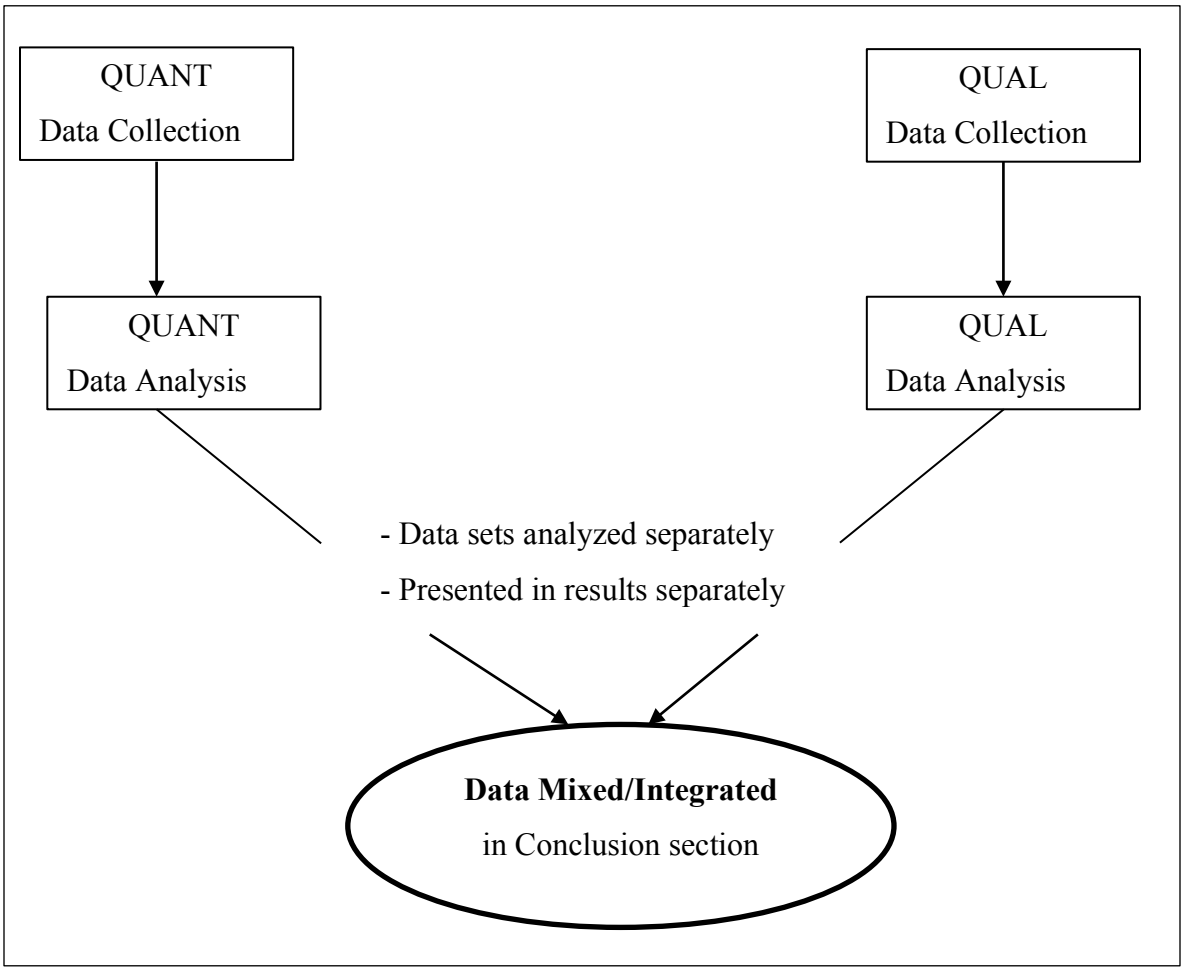


Figure 2 shows the mixed methods design and analytical approach.

Study 1: Quantitative Data

The quantitative sample is part of a national psychiatric study of Latinos and Asian Americans. The National Latino and Asian American Study (NLAAS) is one of three nationally representative surveys on mental disorders. This initiative is known as the Collaborative Psychiatric Epidemiology Surveys (CPES) and was supported by the National Institute of Mental Health. The CPES is a national effort to provide prevalence of psychiatric disorders among Whites and minority groups. It also provides data on cultural and ethnic factors related to mental health. The NLAAS is the best archival dataset with a large Latina/o adult sample and with constructs of interest—risk factors, resilience-related constructs, and depression.

Data Collection Procedures

Only a brief description of the data collection procedures is presented here; for a detailed description see Pennell et al. (2004). The Institute for Social Research at the University of Michigan collected the data between 2002 and 2003. The Institutional Review Board Committees of the Cambridge Health Alliance, the University of Washington, and the University of Michigan approved all recruitment, consent, and interviewing procedures. Professional lay interviewers administered the interview and the interview's average time was 2.6 hours. Eligibility for the Latino sample consisted of being 18 year of age or older, identifying as Latino, Hispanic or Spanish decent, and speaking English or Spanish. The data used in this study is de-identified.

Measures

Demographics

Demographic information was collected through a series of questions, including age, ethnicity, gender, nationality, age of immigration, marital status and number of children. Age,

for instance, was represented with four categories (18-24; 25-34; 35-49; 50-64; ≥65). Level of education included four categories: some high school (0-11); high school graduates (12); some college (13-15); college degree or greater (≥16). These categories are consistent with other NLAAS publications (M. Alegría et al., 2007). The NLAAS survey included an array of measures, most of which were translated into Spanish. Some of the instruments were adopted from other Latino mental health studies, some were culturally adapted and others were developed for the study (M. Alegría et al., 2004). Appendix G contains the NLAAS measures included in the present study.

Depression

The prevalence of depression was measured with the World Health Organization Composite International Diagnostic Interview, also known as the WMH-CIDI. The CIDI is a diagnostic instrument that resembles criteria from the DSM-IV (Kessler & Üstün, 2004). Based on this diagnostic instrument, ICPSR created one variable to indicate whether or not respondents endorsed having a major depression in the past 12-months. This dichotomous indicator of major depression episode was used as the outcome variable. The original item's two categories were endorsed (=1) or not endorsed (=5). This item was recoded so that a score of zero represented no depression and a value of 1 indicated depression.

Risk Factors

Consistent with the conceptualization of risk factors in the literature review, the following three risk factors are examined as indictors of depression: (1) financial strain, (2) perceived discrimination, and (3) family cultural conflict.

Financial strain, a proxy measure of social disadvantage, was measured with 1-item that assessed the extent to which women had sufficient means to meet their needs. Specifically,

women were asked, "In general, would say (you have/your family living here has) more money than you need, just enough for your needs, or not enough to meet your needs? The scores ranged from one to three and higher numbers indicated more financial strain. The variable's mean was 2.40 (SD = .58).

Perceived Discrimination was measured with 3-items that assessed perceiving discrimination as the result of the person's race or ethnicity. A representative item is "How often people dislike you because you are [ethnic/racial group of respondent]?" The response categories are: often, sometimes, rarely, and never. The scale was recoded so that higher scores indicated higher levels of discrimination. When the items were averaged, they produce a mean of 5.15 (SD = 2.30) and a satisfactory Cronbach's alpha of .81. The scale was going to be used in its original metric; however, as explained in the preliminary analysis section, as a result of low proportion of responses in some categories and issues related to estimation, three categories were collapsed in order to conduct the regression analysis. The scale with the collapsed categories maintained a satisfactory Cronbach's alpha of .81. The mean was 4.35 with a standard deviation of 1.27.

Family cultural conflict, a measure of family conflict including intergenerational conflict between respondents and their family was the closest measure to family stress. The family cultural conflict scale, made up of 5-items, was used as a proxy measure of family stress. These items are part of the Hispanic Stress Inventory (Cervantes, Padilla, & Salgado de Snyder, 1991). One of the scale's questions is "Because of the lack of family unity, you have felt lonely and isolated." The questions have the following response categories: hardly ever or never, sometimes, and often. The scale has a mean of 6.48 (SD = 2.07) and good internal consistency (α= 0.80). As with the perceived discrimination scale, the original family cultural conflict scale

was unfit for the analysis (more details are provided in the preliminary analysis section). Thus, the scale was dichotomized using a median split approach. That is, respondents with a score below the median were recoded as 0, indicating low family cultural conflict and those with a score above the median were recoded as 1 indicating family some/high family conflict. The new version of the scale had an acceptable internal consistency of .75, and a mean of 5.26 (SD = .79).

Family Resilience

Some measures consistent with family resilience theory, such as religion (related to family schema) and family relational wellbeing (Bermudez & Mancini, 2013; L. D. McCubbin & McCubbin, 2013) L. D. McCubbin and McCubbin (2013) were selected as measures of family resilience for the present study.

Family schema are the identities including values, beliefs, practices and expectations to which families attach meaning and use as guides (L. D. McCubbin & McCubbin, 2013). In the present study, family schema was assessed with a question about *religion* (the other religion question in the data was a count variable). Women were asked about the frequency of seeking religious comfort when experiencing difficulties in their family, work, or personal life. The raw scores were reverse coded so that higher scores indicated higher levels of religiosity. This variable had a mean of 2.88 and standard deviation of 1.150.

Family relational wellbeing was assessed through four questions, which asked participants to rate family relations, the extent to which they could share their feeling with their family, and closeness among family members. These questions are part of two subscales from the Circumplex model of family resilience (Olson, 1988). Some of the statements are: “We really do trust and confide in each other.” “We can express our feelings with our family.” The response categories included: strongly agree, somewhat agree, somewhat disagree, and strongly disagree.

The items were selected based on their content and relevance to the predictors and outcome variables. In order for higher scores to represent higher family relational wellbeing, the raw scores were reverse coded. These items together, as a scale, had acceptable reliability (α= 0.75) and mean of 5.26 (SD = 0.62). Further, since this measure was also used a moderator variable, it was dichotomized into high and low to ease interpretation.

Control Variables

A covariate is a secondary variable of interest that correlates with the outcome variable and had to be adjusted (Tabachnick & Fidell, 2013). Consistent with previous literature (M. Alegría et al., 2007), in the present study age and nativity were controlled.

Data Analytic Strategy

All analyses were conducted in SPSS Statistics software package (Version 23). Logistic regression is a common analysis approach to identify the presence or absence of a condition or disease (Hosmer Jr & Lemeshow, 2000). Logistic regression was used because it allows the researcher to adjust for covariates and testing of interaction effects (Hosmer Jr & Lemeshow, 2000). Since all the variables in the analysis were discrete or dichotomous, for all three predictors and for the covariate age, the lowest category was set as the reference category. On the other hand, given the comparisons of interest for the two moderator variables and for nativity, the highest category was set as the reference category. This allowed the researcher to compare whether women with low levels of religion would be more likely to report depression.

Analysis of Research Questions 1 and 2

Research Question 1: To assess whether risk factors predicted depression while controlling for age, and nativity, I ran one hierarchical logistic regression with the control variables entered in the first step and three predictor variables (financial strain, discrimination,

and family conflict) entered in the second step. Based on the results, I assessed model fit and reported on the individual contribution of each predictor.

Research Question 2: To assess moderation by family resilience variables (religion and family wellbeing) when predicting depression from risk factors (financial strain, discrimination, family conflict), I conducted a series of hierarchical logistic regression analyses. The model previously described (to answer question one) was tested again, but this time the two moderator variables were added to step two. By adding religion and family wellbeing, the moderators examined their main effects.

Building on the previous model, two more models were run to test for the interaction effects of religion and family wellbeing. To create the interaction terms, I used the significant predictor variables (finance, discrimination and/or family wellbeing) and multiplied each by the corresponding moderator variable. For instance, once I had created the interaction terms, between religion and discrimination and between religion and family conflict, I added them to the model and then ran it. I repeated the process for the second moderator, family wellbeing.

Study 2: Qualitative Data

Research Paradigm and Theoretical Approach

The interpretive/constructivist research paradigm was used for the qualitative component of the study. However, given the overall mixed methods design of the study, some aspects of this paradigm are not applicable—mainly in terms of in-depth and long-term data collection. According to the constructivist paradigm, knowledge is socially constructed through interactions between people, such as the researcher and the participant, thus knowledge is not an objective reality (Haverkamp & Young, 2007). This paradigm acknowledges the researcher's values in the research process and expects the researcher to engage in reflexivity by examining his/her bias,

values and beliefs. The integrated family resilience framework was used as the theoretical approach. Specifically, the three family resilience categories described in the R&RTEFS and the similar categories described in *Familias Fuertes* framework.

Data Collection

The qualitative component of this dissertation was obtained through data collection. IRB approval was obtained through Michigan State University's Human Research Protection Office before data collection began. Women were recruited from a mental health and substance abuse Latino community organization in Atlanta. Prior to data collection a collaborative relationship was established with this organization.

A purposive sampling approach was used given the purpose of collecting the qualitative data, to learn more about the nuances of depression, its risk factors and family resilience. Thus, criteria for participation included self-identifying as Latina or Hispanic, having experienced depression in the past, being over 18 years of age, being part of a family configuration (i.e., having children and/or being married or having a partner). Women who were experiencing current clinical depression symptoms, women who were bereaving, or women who were receiving therapy for depression were not interviewed for this study. I used a screener form (see appendix B and C) to determine participants' eligibility for the study. I screened a total of 42 women of which 19 were not eligible to participate. Some of the women who were eligible and interested in participating did not show up to the scheduled interview, and another subset of eligible women did not have time to participate.

I conducted a total of fifteen, face-to-face, semi-structured interviews with Latina women from the Atlanta community. Informed consent (see Appendix D and E) was obtained before the beginning of each interview. As a token of appreciation for the women's time and participation,

they were given a $20 gift card to a retail store. At the end of the interview, women who became distressed or disturbed during the interview were encouraged to access therapy services offered at the organization and the contact information to the appropriate staff member was provided.

Interview Guide

The interview guide (appendix E and F) was developed based on the literature review and the proposed theoretical framework. This approach aligns with qualitative methodology (Glesne, 2011). The questions in the interview guide broadly reflect the three main constructs of interest—depression, depression's risk factors, and family resilience. In order to build rapport with participants, I started the interview by asking some demographic questions. The interview guide included several questions that explore women's experiences being a woman and being Latina. These questions were designed to capture the intersectionality aspects, and potential risk factors such as gender oppression, that the quantitative measures do not capture. The last part of the interview includes a set of questions related to depression and resilience. The interviews were conducted following feminist research principles, such as creating a safe space for the participants and conducting the interviews in a woman-centered manner—less hierarchical, showing empathy, and respect (DeVault, 1996, 1999; Oakley, 1981).

Analysis Approach

Thematic analysis (Braun & Clarke, 2006; Guest, MacQueen, & Namey, 2011) was used as the qualitative analytic approach because it offers a viable option for answering the qualitative research questions. "Thematic analysis is a method for identifying analyzing and reporting patterns (themes) within the data" (Braun & Clarke, 2006, p. 79). This approach is appropriate because it allows describing both implicit and explicit ideas in the data (Guest et al., 2011). The purpose of using this analytic approach is to provide a detailed and nuanced account of the risk

factors and family resilience mechanism described by Latina women. This approach aligns with the research questions (Braun & Clarke, 2006). Given that the family resilience framework guided the research questions, the themes were identified in a theoretical or deductive approach (Boyatzis, 1998). Thus, this approach is driven by the researcher's theoretical interest in the data and it is considered a theoretical thematic analysis (Braun & Clarke, 2006).

Thematic Analysis: Coding & Analysis

I followed Braun and Clarke's (2006) six phases of thematic analysis to analyze the data. Phase one involves familiarizing oneself with the data; in this phase I read the transcripts and took notes. In phase two, generating initial codes, I systematically coded the entire data set for content that was related to the research questions. In order to follow a system in my coding, I developed a preliminary codebook with code definitions. Phase three of the analysis involved searching for themes. I collapsed (combined) codes that had similar content under a broader category or theme. The fourth phase included reviewing the themes. I examined how well the themes captured the coded content and how well the themes fit within the entire dataset. The fifth phase required defining and naming themes. In this stage of the analysis, I further examined the themes by revising the themes' content and assigned labels or names to the themes. The sixth and last phase of the analysis blurs with writing of the results. Thus, in this part of the analysis I selected salient extracted quotes as examples. I presented these examples in the themes according to the research questions and in line with the resilience frameworks.

Trustworthiness refers to the quality of the analysis and results of qualitative data. Thus qualitative research must achieve four criteria: (1) credibility, (2) dependability, (3) confirmability, and (4) transferability (Morrow, 2005). *Credibility* refers to a clear and accurate reflection of participants' experiences through the findings. This was achieved by using a

codebook with clear definitions and examples. The codebook will ensure a systematic coding process.

Dependability and *confirmability* are interrelated concepts. They highlight the importance of using adequate methodology to ensure reasonable findings. This was achieved by following all the six phases of thematic analysis (Braun & Clarke, 2006). I also obtained feedback on the coding and analysis process from an expert coder. Lastly, I created an audit trail system with detailed notes of the data collection and analysis.

Transferability refers to the "usefulness" of the results in terms of its application and relevance to the larger population that sample represents (Sandelowski, 2004). Transferability was achieved by applying the following: memoing, reflexivity and thick descriptions. I created memos to capture the context of giving meaning to the data, specifically in creating and revising codes and themes. I also engaged in reflexivity or the process of critically thinking about how my position, values, and biases influence the analysis process. Lastly, I provide thick descriptions of the results in the qualitative findings chapter.

CHAPTER 4: RESULTS

Study 1: Quantitative Results

Study Sample

Only the subsample of Latina women in NLAAS (N=1,427) was included in the present study. Six participants were removed from the data set because of significant missing data or because they had responses that were considered multivariate outliers, more information about this is provided in the preliminary analysis section. Thus, the final sample size was 1,421. The women's average age was 41 (SD =16), with 63% of them being born outside the U.S. The women's racial and ethnic background was classified based on the four major U. S. categories. The majority of women (33%) identified as Mexican, followed by those who identified as "other Hispanic (26%). About 58% of the women were married or cohabitating, 24% were divorced, and 18% had never been married. The majority of the women (82%) were mothers. Of these women, 18% had only one child while 48% had two to three children. On average, women had completed 10.78 years of education. Over half (52%) of the women were employed, 7% unemployed and the rest were not in the labor force. Almost one third (32%) of the women reported an annual income of less than $15,000, and about 30% reported an annual income between $15,000 and $ 34,999.

Preliminary Analysis

Before analyses were conducted, financial strain, discrimination, family cultural conflict, religion, and family cohesion were examined for accuracy of data entry, missing values and multivariate outliers. Variable distributions and assumptions of multivariate analysis were not applicable given that the variables were categorical and analyzed through logistic regression (Tabachnick & Fidell, 2013). The missing variables analysis in SPSS revealed that three

participants had 88% of missing data across variables of interests. As a result, these three cases were deleted from the data set. Multivariate outliers were identified using Mahalanobis distance, any cases with a Mahalanobis distance greater than 20.515 is considered a multivariate outlier (Tabachnick & Fidell, 2013). The results indicated that three cases were multivariate outliers through Mahalanobis distance. These three outliers were deleted, leaving 1421 cases as the final sample size for analysis.

Bivariate Analysis

A set of chi-square (χ^2) test of independence was performed to examine the relationship between each predictor variable and the outcome. The chi-square test "compares the frequency of cases found in the various categories of one variable across the different categories of another variable" (Pallant, 2013, p. 212). Initially, five bivariate associations with depression were tested. The results indicated that financial strain was significantly associated with depression, χ^2 (2, n = 1405) = 12.48, $p < .05$. The Chi-square results of the other two risk factors, discrimination and family cultural conflict, although statistically significant, violated the Chi-square assumption of minimum expected cell frequency (Pallant, 2013). Meaning that, more than 20% of cells had an expected count cell of less than 5% (Pallant, 2013). This issue would have affected the logistic regression analysis as well because having small expected frequencies could have little power for logistic regression (Tabachnick & Fidell, 2013). To address this estimation problem, variable categories with small percentages were collapsed (Tabachnick & Fidell, 2013) .

Discrimination Scale

To collapse categories, the frequency of responses for the discrimination items was examined, and it was determined that the fourth category ("often") had the lowest percent across

all 3 items (between 2 and 8 percent). Thus, the category of "often" was collapsed with the category of "sometimes." But after reexamining the new scale with the three categories in another Chi-square test, the assumption was still not met. Then the process was repeated and collapsed into two more categories: often/sometimes with rarely. Another Chi-square test was conducted; however, the results showed that issues persisted and would still be problematic for the logistic regression analysis. As such, I decided to create a median split variable or a binary categorical variable of the total score. The results of this binary variable had adequate expected frequencies, and the Chi-square results indicated that discrimination was significantly associated with major depressive disorder, χ^2 (1, n = 1420) = 12.310, $p < .05$.

Family Cultural Conflict Scale

A similar approach was used to address the expected frequency issue and assumption violation of the family conflict scale. The original categories in the variables were: hardly ever or never, sometimes, and often. The last two categories had the lowest percentages, 19.4 and 6.3, respectively. Thus, the "sometimes" and "often" categories were collapsed. After examining Chi-square results of the new scale with two categories, the assumption was still violated. Thus, I decided to create a binary categorical variable of the scale's total score. This new version of the scale no longer violated the assumption and was also significantly associated with depression, χ^2 (1, n = 1421) = 33.04, $p < .05$.

The last two bivariate associations tested were between religion and depression and family wellbeing and depression. The Chi-square test result indicated that there was no significant association between religion and depression, χ^2 (3, n = 1420) = 1.183, $p = .75$. On the other hand, family wellbeing was significantly associated with major depressive disorder, χ^2

(1, n = 1421) = 6.057, $p < .05$. In sum, the bivariate analysis revealed that all of the measures, except for religion, had a significant association with depression.

Research Question One: Results

Research Question 1: Do risk factors, such as social disadvantage (financial strain), racial/ethnic discrimination (perceived discrimination), and family stress (family cultural conflict) predict major depression in the last 12 months? To answer this question and its corresponding hypotheses, I conducted a hierarchical regression model in which financial strain, perceived discrimination and family cultural conflict were analyzed as predictors of depression, while controlling for age and nativity. A good model fit for the three predictors were as follows: financial strain, perceived discrimination and family cultural conflict controlling for age and nativity, χ^2 (8, N = 1404) = 48.379, $p < .05$.

But despite the good model fit, the overall classification did not improve based on the predictors. The correction classification was 100% for women with no depression and 0% for women with depression, and the overall correct classification rate was 88%. This classification rate was did not change in the rest of the models regardless of the addition of other variables in the models. This seems to be, in part, the result of having over 80% of women in one category, and none of the women with depression were correctly classified. This finding is addressed in detail in the discussion section.

Table 2 shows regression coefficients, Wald statistics, odds ratios, and 95% confidence interval for each of the predictors (three risk factors) and the two covariates. Adjusting for age and nativity, financial strain was not a predictor of depression while perceived discrimination and family cultural conflict were significant predictors. The results are presented next according to their corresponding hypothesis.

Table 2. Logistic Regression Analysis of Depression Predicted by Risk Factor Variables: Financial Strain, Family Conflict, and Discrimination

Variables	B	Wald χ^2- test	Odds Ratio	95% Confidence Interval for Odds Ratio	
				Lower	*Upper*
Age 18-34 vs. 35-49	2.47	1.578	1.28	.871	1.881
Age 18-34 vs. 50-64	-.030	.014	.97	.589	1.589
Age 18-34 vs. 65 and up	.287	.939	1.33	.745	2.383
Foreign born vs. U.S.	.106	.350	1.11	.783	1.579
Finance: low vs. medium	.060	.018	1.06	4.38	2.578
Finance: low vs. high	.554	1.528	1.74	.722	4.195
Family Conflict: low vs. high	.795*	21.438	2.21	1.582	3.100
Discrimination: low vs. high	.420*	6.068	1.52	1.089	2.127

*Significant at .05.

Hypothesis 1: Women with more social disadvantage, in the form of financial strain will be more likely to report depression than women with lower levels of financial strain. Hypothesis was not supported because, compared to women who had more than enough money to pay their

bills, women who reported not having enough money to pay their bills were unlikely to report a major depressive episode in the last 12 months, *OR* = 1.74, *p* = .217, CI [.722 – 4.195].

Hypothesis 2: High perceived discrimination would predict depression. Women who report perceived discrimination, compared to those who do not report perceived discrimination, will also report an episode of major depression in the last 12 months. Hypothesis 2 was supported; women who reported perceived discrimination were one and half times more likely to report depression, *OR* = 1.52, *p* < .05, CI [1.089 – 2.127].

Hypothesis 3: Family stress, in the form of family cultural conflict, will predict a major depression episode. Women who report high levels of family cultural conflict will be more likely than women who do not report high levels of family cultural conflict to report depression. Hypothesis 3 was also supported; family cultural conflict was a significant predictor of depression. Women with high family cultural conflict were over two times more likely to report a major depressive episode, *OR* = 2.21, *p* < .05, CI [1.582 – 3.100].

Research Question Two: Results

Research Question 2: Does family resilience, in the form of religion and family wellbeing, moderate the relationship between risk factors and depression? A series of hierarchical logistic regression models were conducted to answer this question. The main effects of religion and family wellbeing were not significant. Specifically, compared to women who often sought comfort in religion, women who never relied on religion were not more likely to report depression, *OR* = 1.19, *p* = .439, CI [.766 – 1.850]. Family well-being was not a predicator of depression, *OR* = 1.11, *p* = .575, CI [.767 – 1.614]. Model three corresponds with testing hypothesis one. *Hypothesis 1*: Religion (family schema construct) will moderate the relationship between risk factors and depression such that depression will be more likely to occur among:

1a. Women with low religion and more financial strain

1b. Women with low religion and high levels of discrimination

1c. Women with low levels of religion and high levels of family cultural conflict

Hypothesis 1a was not tested given that financial strain was not a predictor of depression as revealed in model one. The results of the analyses in model three showed that religion does not moderate the relationship between perceived discrimination and depression and between family cultural conflict and depression. This lack of moderation is indicated by the non-significant interaction terms between perceived discrimination and religion. Specifically, compared to women with high levels of religion (such as women who sought comfort through prayer, mediation, or attending a spiritual service) and low levels of discrimination, women with low levels of religion and high level of discrimination were unlikely to report a major depressive episode in the last 12-months, $OR = 1.53$, $p = .349$, CI [.627 – 3.750]. Thus, hypothesis 1b was not supported. Religion also did not moderate the relationship between family cultural conflict and depression. Women with low levels of religion and high levels of family conflict were not more likely to report depression than their counterparts (women with high levels of religion and a low levels of family conflict), $OR = 1.209$, $p = .677$, CI [.496 – 2.944]. As a result, hypothesis 1c was also not supported.

Model three shows the result for testing hypothesis two. Hypothesis 2. Family relational wellbeing will moderate the relationship between risk factors and depression such that depression will be more likely to occur among:

2a. Women with low family relational wellbeing and more financial strain

2b. Women with low family relational wellbeing and high levels of discrimination

2c. Women with low levels of family relational wellbeing and high levels of family cultural conflict

Hypothesis 2a was not examined because financial strain did not predict depression. The other two hypotheses, 2b and 2c, were examined in the model: moderation between family wellbeing and discrimination on depression, as well, as the moderation between family wellbeing and family conflict on depression. Women who perceived more discrimination and had low levels of family wellbeing were not more likely than women with low perceived levels of discrimination and high levels of family wellbeing to report a major depressive episode in the previous year, *OR* = .723, *p* = .349, CI [.366 – 1.426]. Thus, hypothesis 2b was not supported. The results indicate that family wellbeing does not moderate the relationship between family conflict and depression. In other words, women with low family wellbeing and high family conflict were as likely as women with high family wellbeing and low family conflict to report depression, *OR* = 1.088, *p* = .824, CI [.518 – 2.985]. This indicates that there is no evidence to support hypothesis 2c.

Study 2: Qualitative Findings

Study Sample

Except for one woman, the women (N=14) who participated in the interviews were from Mexico. On average women had lived in the U. S. for 15 years with a range of 1 to 24 years. The women were between the ages of 25 and 46. They were all mothers—one woman had seven children, and the remaining women had a range between two and three children. One third of the women were single mothers, while the rest were married or cohabitating. Similarly, over one third (N=6) of the women were unemployed; two of these women stopped working after one of their children became permanently ill. The women who were employed worked in service jobs

such as restaurants, hotels, and bakeries. Women's education ranged from second grade to technical training; the majority of the women, however, only completed middle school. Income information was not asked; however, considering their education levels and employment history, all of the women would be considered of low socioeconomic status. The aim of the qualitative study was to answer research question 3 and 4:

Research Question 3: What risk factors do women describe as salient to their depression experiences? How do different forms of discrimination, such as sexism and racial and ethnic microaggressions relate to depression?

Research Question 4: How do women describe experiencing family resilience related to depression? What aspects of the family resilience framework are present in women's experiences of depression? Table 3 illustrates the findings, by theme, for both risk and resilience factors. As illustrated in table 3, five themes were identified as main risk factors that triggered or contributed to the women's depression. Some women described their depression as a terrible experience, while others did not fully embrace the term, despite describing symptoms. The main themes or risk factors are: (1) children's health, (2) family problems and stress (3) financial strain, (4) gender oppression, and (5) racism.

Risk Factor 1: Children's Health

Some women's risk factors for depression included children's physical and mental health and their behavioral problems, and in some cases those problems contributed to the women's depression episode or depression relapse. Three subthemes emerged: (1) children's behavioral and psychological problems, (2) children's chronic health problems, and (3) family health embedded in family relations.

Table 3. Themes from Thematic Analysis

RISK FACTORS		PROTECTIVE FACTORS: Family Resilience
RISK FACTOR 1: Children's Health ➢ *Children's behavioral & psychological problems* ➢ *Children's chronic health problems* ➢ *Family health embedded in family relations.* **RISK FACTOR 2: Family Conflict and Family Stressors** **RISK FACTOR 3: Financial Strain** **RISK FACTOR 4: Gender Oppression** ➢ *Domestic violence* ➢ *Childhood sexual abuse and rape* *Sexism: men & machismo* **RISK FACTOR 5: Racism** ➢ *Language discrimination* ➢ *Racism at work* ➢ *Law enforcement & racism* ➢ *Racism from multiple ethnic groups*	DEPRESSION	**FAMILY SCHEMA** **Children as strength & Motherhood** ➢ *Children as strength and motivation* ➢ *Mothers as role models* ➢ *Mother identity* **Religion, Spirituality & Faith** ➢ *Religion and church support* ➢ *Faith & spirituality* **Cultural Values** **PATTERNS OF FUNCTIONING** **Social Support** ➢ *Nuclear support: partners* ➢ *Extended family support* ➢ *Transnational families* ➢ *Low family support* ➢ *Girl friend support*

Children's behavioral & psychological health problems

Over half of the women (n = 9) described their children's behavioral and psychological problems as direct and indirect influences of depression. For instance, three women, with children under twelve years of age, were concerned about their children's behavioral problems. One of them had her twin sons in therapy because they did not talk at school. In another case, a woman's daughters showed symptoms of posttraumatic stress disorder as a result of their parents' divorce. These girls had also witnessed stalking and domestic violence. Adolescents' psychological and behavioral problems included externalizing (i.e., anger, aggression, cutting themselves [3 of them], experimenting with drugs) and internalizing (i.e., depression) behaviors. For some women, their child's behavioral and psychological problems also involved a lot of parental conflict. For instance, one male adolescent has resentment against his mother for leaving him in Mexico for a week. Besides fighting constantly with his mother, he also started cutting himself. The following is about Julia's (39) adolescent son: "sometimes I feel disappointed, um well … But yes sometimes I feel like that, sad … I start crying, when he behaves badly and with all that he tells me."

Other women, similarly, shared their struggles with their children's behavioral and psychological problems: "I feel bad because, it feels bad that your kid tells you that they don't love you, right. I feel bad. But I try not to pay too much attention to her, ignore her, because if I pay attention what's going to happen is that am going to get depressed" (Adriana, 30). Laura (38) described her daughter's depression as follow, "It was horrible, she [my daughter] had a depression with her room dark, her bed dark, the curtains dark. … she cut herself and things like that. This was very difficult for us. Very difficult."

Sometimes women had to make difficult decisions and sacrifices to help their children. However, such decisions took an emotional toll on the women. The following quote illustrates a single mother's dilemma in dealing with her bipolar (she shared that he was professionally diagnosed) teenage son.

> "It's been 5 years since I sent him to Mexico [to live] with his father because since he is male and he was 15 years old. I was having a lot of problems with him and I could not control him because he was starting to get too aggressive, very aggressive and I was afraid that he would hit me, and in hitting me that something bad would happen to me. Then that would be a big trauma for him… His dad is older, a man and even if he gets aggressive with him, he will be able to control him. … Up until now I would have wanted him no to leave because he always lived with me and I keep missing him." (Lucia, 46)

Children's chronic health problems

Three women described their children's health rapidly declining and developing chronic conditions (e. g., epilepsy, febrile seizures, and muscular dystrophy). One woman described her child's health problems, which involved frequent hospitalizations and surgery; she indicated that this experience almost caused her to relapse into depression. All three women described their child's illness as very difficult to deal with. The following quote illustrates this:

> "[My] 17 years old has epilepsy, she developed at the age of 5. We suffered a lot with her, a lot. …She would get convulsions every 5 minutes. … I spent an entire year sleeping one hour because I had to monitor her convulsion at night" (Sofia, 33).

For one woman, dealing with her daughter's illness coupled with her recent divorce and short arrival from Mexico, directly contributed to her depression. After becoming a single mother with two small girls and her oldest daughter becoming very sick, she described the following:

> "I felt that my world was closing because when you feel like that, you are in a country that is not yours to begin with, a language that you don't dominate. You are used to, that if your husband takes somewhere, you go somewhere. Then my oldest daughter started having febrile seizures. I had to be in the emergency room two to three times a week. I think those were my biggest depressions. When I did not know what I was going to do or where I was going to work. Um, how was I going to move because I did not have a car, I did not know how to use the bus. And my daughter was almost everyday in the hospital" (Gloria, 33).

Family health embedded in family relations

The embedded nature of family relations and health was highlighted in some women's stories. For instance, Lucia (46) indicated that her daughter's isolation and depression resulted from her son's departure to Mexico. She decided to send him to Mexico because she could no longer control his aggressive behaviors. In another example, Ana (39) indicated that her youngest child's illness contributed to her oldest child's psychological problems. She noted that for a while she could not figure out what was affecting her oldest son. She sent him to therapy, but he would not engage with the psychologist. This troubled her, so she had a conversation with him. And he told her that, "simply, I am sad because of my brother." When Ana's youngest child's physical health improved, her oldest son's psychological health also improved. Ana (39) noted that, "now since my kid has seen his [sick] brother get better; he is much better."

Risk Factor 2: Family Conflict and Family Stressors

Family conflict, with both nuclear and extended family members, contributed to family members' tenuous relationships and in some instances to depression. Several women indicated struggling with their partners over parenting differences. These couples' disagreements about parenting contributed to both their children's behavioral problems and also to marital problems.

After ending a romantic relationship or losing important family relations, several women found themselves negatively affected. One of the youngest women in the study shared one of her many experiences of depression and highlighted the following connection between family problems and depression:

> "I think that the more problems you have the more depression you will have, depends on the life one has… because sometimes regardless of how small the problems are in life, they could be with your family, with your mom or dad. Like in my case, I don't know my dad and I think that also because I don't know him and when I have needed him in special moments is depressive too" (Rebecca, 25).

The rupture of a romantic relationship pushed some women over the edge, causing them to feel desperate, lonely, unsupported, and overwhelmed with parenting responsibilities. Similarly, severing close family relationships or losing a close family member contributed to women's depression. The following provides insight into the women's experiences after leaving a relationship:

> "What affected me was the separation [from my husband] because I had just moved from Mexico when I had problems with my husband. I had been here two months and we ended. Then practically I was on the streets without knowing anyone and without having anyone here. For me it was very difficult to stay here in the United States by myself and also with my daughters. Wanting to work and not being able to, it was very difficult" (Silvia, 29).

Ana (39) noted that her partner at the time did not abandon her and her child, but simply moved back to Mexico while she decided to stay, "I cried a lot, I didn't want to go out. Um, what happened was that my youngest kid's father left, he left when [my kid] was a year old. Then, that

hurt me a lot." Ana was aware that her decision to stay would end their relationship and that she would be alone with her child. Jimena (31) described her most recent (last year) depression episode, which was caused by ending a romantic relationship. She shared the following: "recently I dealt with something really ugly. … I don't know, well I had a partner and we had problems and he ends up telling me that I wasn't (long pause), that I was not a good enough woman. And then I got really depressed."

Broken family relations or losing a close relative such as a mother greatly affected some women. For example, Irma (41) who lost contact with her son after divorcing her husband, she moved to a different state because her ex-husband kept stalking and offending her. Despite her efforts, her ex-husband convinced their teenage son to move away from his mother and finish school where the ex-husband lived. The ex-husband also successfully poisoned their son's mind by telling him that his mother did not care and that is why she left. Irma (41) noted, "I completely lost the relationship with my son. It was a rupture for more than a year without wanting to talk to me, without answering the phone." Lucia (46) described becoming more depressed after losing her mother (who was her main source of support). She also noted that other contributing factors were her brother's divorce (his marriage was another strong source of support for her) and being alone. The interconnections of family relations is illustrated in the following quote:

> "A month after they [my brother and sister-in-law] separated, my mom died. Then my strongest pillars fell because it's not the same for them to be individually than as a solid couple, who I trusted a lot in. I think since then more depression. …Yes I get [depressed], more often and because every time life is harder being alone (laughs). Yes, practically I have spent my entire life raising my kids by myself. For some reason, I have not been able to

consolidate a relationship with a partner; we have ended the relationship even having a kid already."

A few other women (n=3) experienced depression, two during pregnancy and one postpartum. This was caused by not having their partners and feeling lonely, stressed, and unsupported. The following is from Sandra (46):

> "I had a terrible depression. I was afraid of hurting this girl [her daughter]. She would make me hysterical. … My daughter's dad travels a lot [he transports food across states] and he's rarely here. …There are moments that one gets frustrated and needs support. I was going through something terrible with my parents who were very bad and this girl too, and I would feel sadness for my boy, [he would ask] 'mom, why are you crying?' 'mom what's wrong?'… And up until today am still struggling. I told my daughter's father 'you need to change jobs. If you don't change, am going to stay by myself. I don't need anybody like that."

Risk Factor 3: Financial Strain

Overall, two thirds (n=10) of the women had financial struggles, some more severe than others. Financial struggles compounded women's stress. Some participants explained the connection between financial stress and depression. For example Lucia (46) noted, "many times I get depressed because am left with no money and I need money to pay for things, umm, it's very depressing many times." A few women experienced very difficult financial situations; two of them became homeless and another one lost her house (because of lack of work) and had to move into an apartment. Sandra (46), for instance, was another woman who was temporarily homeless. She blames her partner as the sole reason for her homelessness. She indicated that her partner gave priority to his car over their house. She stated,

"I ended up on the streets, I ended up on the streets, horrible. … You know, that hurt me a lot. … I did not have anywhere to live because he needed his car. Can you believe that?... And honestly, deep inside I will never forgive him for that." When this happened, she felt isolated and she refused to seek family support, as she believed her family would scold her and encourage her to leave her partner. Sandra indicated that she felt ashamed and that she refused to tell her best friend, whom she considered family.

The lack of support from partners exacerbated their financial struggles, and in some cases becoming independent from previously relationships caused many to struggle financially. Three women, in particular, described vivid and painful experiences as single mothers. They all depended on their husbands (two of them had recently arrived to the U.S., they were quoted elsewhere) and the transition to single mother was challenging. After becoming a single mother, Ana (39) described her financial situation as follows:

> "I depended on him. I struggled a lot to find work and, um that was also part of my desperation. I could not find work. I had to pay bills. My parents helped but it was not the same. My desperation was so much because of not finding work, not having money, being alone…that was also what I felt, I didn't know what to do."

In another example, Liliana (34), who worked a stressful job, indicated that she could not pay her rent if she missed work, as her husband only worked a few hours. This weighed on her, as she began to cry in the interview, she noted the following, "I don't show my children sometimes that I feel this way…I hold it in and work is heavy. And I have to go to work, as I tell you. Sometimes I work more than he [my husband] does."

Both Liliana and Sandra had similar experiences, as both had very little partner support and very little financial support. Despite both women wanting to leave their partners, they both

stayed because they wanted their children to grow up with their father (this phenomenon is related to cultural values, and as such is discussed more in detail in that section).

Risk Factor 4: Gender Oppression

Several women disclosed abusive and traumatic stories, but part of their stories were about survival and resilience. Given the depth and breadth of the women's experiences, the following three subthemes characterized the theme of gender oppression: (1) domestic violence, (2) rape and childhood sexual abuse, (3) sexism: men and machismo.

Domestic violence

Almost one third (4 out of 15) of the women were domestic violence survivors. Most of them had left their abusive partners, but the psychological and emotional scars persisted along with trauma and depression. Women were aware of the link between their abuse and depression. Monica's (33) case exemplifies this, as she shared the following as part of her experiences with depression,

> "About a year ago [was my first depression episode]. Actually, well I um years ago. My previous partners, I suffered beatings. They beat me up and I ended up like, I hated men, it was a hate like... My previous partner he left me very beat up, umm he wanted to strangle me because I did not want to go with him, he was very machista. He would tell me 'you must be with another guy.' He grabbed me and he started hitting me on my back with a belt. … I was able to escape and yelled for help. … Since then I started to feel so much hate, it was like I have been traumatized. … My other partner [in a beating when I was pregnant with his daughter] grabbed me by the head and put it [my face] in the toilet bowl. That was a horrible experience, and you know when they do that they humiliate you and you start hating them."

She never informed her current partner about the abuse she experienced from her previous partners. The trauma from previous abusive relationships affected her current relationship because she was always guarded. For instance, even a small physical altercation with her current partner was enough to trigger fear, which caused her to call the cops and have him arrested.

Similar to Monica, the rest of the women who also were domestic violence survivors recognized the oppression and violence they had endured with their partners. For instance, Silvia (29) noted, "In the classes I had and all that was where [I realized that] I had suffered from domestic violence, all the abuses." Irma (41) shared her about transition from being oppressed by her husband to finding freedom:

> "Over there in Chicago, when we separated, even then he would follow me everywhere, everywhere he followed me. I would go somewhere and he would be there. And the worst thing is that he would bring my son with him and he would insult me in front of my kid. … The experience with my ex-partner, I felt very dominated, with a lot of fear. Um, I did not have voice or say. Here [in current state], I actually had the courage to drive. And he would tell me 'I never thought that you would drive.' He would make me feel that I was like this, very little. … The first day when he left my house, I felt like a bird. Seriously, I felt freedom like a bird, I didn't even know which direction to flap my wings after he left the first time."

Not surprisingly, two DV survivors (Monica and Laura) also suffered violence at home growing up. Monica (33) grew up witnessing extreme domestic violence; she described a domestic violence episode in which her intoxicated (drunk) father was chasing her mother because he wanted to kill her with a machete. Her grandparents lived near by, and she ran to their house so they could intervene. She noted that she had more courage than her little sister who

would hide under the bed and tremble in fear. Monica also noted that the domestic violence situation at home was one of the reasons she left her house very young. In the case of Laura (38), she has been married for 17 years to her abusive husband (although she shared that he was changing and becoming a better husband in the last three years). Laura also experienced verbal and physical abuse from her mother. She described her mother as very abusive both physically and verbally. Her mother's abuse traumatized Laura childhood. For example, when her mother would help her with homework, she would yell and hit her, which affected Laura's ability to learn. Her childhood trauma affects her to this day and now she cannot help her kids with their homework.

Childhood Sexual Abuse & Rape

Two women, Jimena (30) and Lucia (46), shared about childhood sexual abuse and rape when describing their depression experiences. Sadly, these two women as well as Monica (DV survivor) described the explicit connection between their experiences of abuse and trauma with both recurrent depressions and problems establishing lasting relationships with men. They were all single mothers; Monica had been with her current partner for three years but she spoke at length about her struggles of being a single mother. Jimena (30) shared that she had experienced depression several times in her life, and at the root of her depression was the sexual abuse she experienced when she was a child, "Well, when I was little they abused me many times and different people from my family too. So that is here in my mind. And that's why I think that if I am with someone it will not be the same because of what I lived in my young age."

In Lucia's case, the cumulative experiences of being molested as a child by one of her brothers, coupled with being raped in her early twenties, continues to haunt her; while she was sharing this information she started to cough nonstop and said that she was having a panic attack

(which she said she had been diagnosed with in the past), at the end of the interview she felt dizzy. The following quote illustrates this:

> "I shared [being drugged and raped, which resulted in my first pregnancy] with my mom and my sister-in-law when my daughter was born. When she was born. Because one of my brothers-in-law when my daughter was born, as a baby, my niece was also a baby, I was not doing well. I didn't want [him] to touch them. I didn't want [him] to touch them because my brother molested me when I was little too. …I could not stand my own brothers getting close to my daughter or my niece. Then my sister-in-law realized that something was going on with me. It was then when I told her. … [when I told] my mom, she didn't say anything (starts coughing nonstop) am starting to get a panic attack, they diagnosed before."

Sexism: Men and Machismo

At different points of the interview women made remarks about men, in particular their partners, describing them as machista (a cultural term, in this context used to describe traditional, stubborn, and sometimes controlling Mexican men). Some women who experienced domestic violence described their abusive partners as machista. Not allowing women to drive or denying mechanic services were other clear ways men gave the message that women were inferior. For instance, Lucia (46) in the following quote demonstrates that she was denied car services on the basis of her gender,

> " Some men have made it obvious that because am a single mother, I took [my car] to a mechanic but he did not want deal with women. [He told me] 'Bring your brother, or your dad, anyone but am not doing business with you."… That's what he told me. What a machista, no?

Even women who failed to acknowledge domestic violence expressed their discontent with their husbands who exhibited coercive control. For instance, Liliana (34) expressed the following statement:

> "…My husband tells me that since I am a woman that I should not drive. I told him, 'I should not drive because of that?' Then he says, 'no, because you are a woman and a man, I should drive.' I told him, no. That's' not the case, right? Men and women are the same. I told him, 'what men do, women do. … Women are more than men because we have to do it all. … We work more than they do.' "

Liliana bought a car and did not drive it, not because of her husband's wishes, but because she was afraid of being stopped by the police, risking the possibility of being deported and being separated from her children.

Some women also described lived experiences of gender discrimination in work settings. Two women, in particular, described gendered discrimination at work, but the women contextualized those experiences in terms of the broader culture and the notion of machismo. Laura (38) described a series of gender discrimination experiences by her brother who was her supervisor at a factory.

She indicated that when work was slow her brother would give work to men even if they were newer than women (including her) who had been working there for a couple of years. This coupled with other discrimination experiences led Laura to quit her job and stay home with her children. In the following quote, Laura describes her brother as an extension of their father: "My brother is very machista. My dad was very machista. My dad left inheritance to all my brothers…My dad was one of those who left inheritances to the males because the women they will be supported by their husbands, no?"

Gloria (33) also explained gender issues at work by contextualizing sexism as part of the Mexican culture,

> "… more than anything in regards to work because men don't tolerate, more Mexican men, don't tolerate a woman giving them orders. … Unfortunately, Mexican men who are raised in Mexico, also those raised here conforming to Mexican style from Mexican parents, [those men] think that women have to depend completely on men. They think that without a man we are nothing. …But what we do know is that men can never be compared to women … I don't think that a man can tolerate even three degrees of pain from giving birth to a child. Men only get a cold and they can't go to work."

Including both Gloria and Laura, several other women pushed back against sexism. This resistance accompanied the women's understanding and narrative of gender relations embedded in cultural norms and practices that sustain sexism.

It is worth mentioning that besides the women who experienced domestic violence and described their partners as machista (domestic violence subtheme), the rest of the women who experienced sexism (in the form of discrimination at work or when receiving services) did not link such experiences to depression. However, it is clear that this latter group of women were affected by sexism, evidenced by Laura's situation who stopped working for her brother, leading to her losing her house because she depended only on her husband's income.

Risk Factor 5: Racism

Ninety percent of the women had experienced or witnessed racism in different, and sometimes in multiple, contexts. Women's narratives of discrimination highlighted the intersection of being low-income and undocumented; women experiencing racism and discrimination at work because of their legal status (being undocumented). Their undocumented

status also played a role in interactions with the police. Overall, four racism subthemes were identified: (1) language discrimination, (2) racism at work, (3) law enforcement and racism, (4) racism from multiple races.

Language discrimination

The majority of the women had experienced discrimination because they did not speak English. Such experiences usually occurred when receiving services (e.g., restaurants), at social offices (e.g., Medicaid office, applying for state ID), or at hospitals. Overall, the women felt that they had been treated poorly, unfairly, or that their applications were denied for no reason. While some women described only a few racist experiences, others like Laura (38) had countless racist encounters over the years:

> "I have had so much racism here that I have cried about it. One time, I went to a phone store, am talking about 20 years ago. I didn't know English. When I got to the store, a White customer was giving his phone number and other information. He was going to sign a contract. [He was asked] 'what is your social security number?' [then he said] 'No, I can't give it to you … because she's here. You think am going to give it you in front of these people who come to steal from us. Why don't you ask her for her social security number'… I felt so bad."

According to the women's narratives, social services offices were a common place where women encounter racism. Sandra's case exemplifies this, as she had been denied Medicaid for her daughters: four times. Over time she qualified for Medicaid but this is how she described the process "I have been trying and trying in different offices until they gave it to me. But in reality that was a horrible experience. … It should be the case that, since they are public employees,

they treat everyone the same, but they treat people differently." Similarly, Jimena (30) shared that,

> "At the Medicaid office, a Black woman was helping me and she spoke to me in English, but I don't know English. So she told me, 'this country is to come and learn English, it's not to stay the same, then what did you come here for?' And I felt really bad because of that. She should not care about that [me not knowing English]."

Some of the women explicitly associated their race/ethnicity, or being Latina, with being treated differently because they did not speak English. Irma's (41) quote illustrates as follows,

> "Latina means the language, no? that connects the rejection, which I have felt in several occasions. Why? Because of the language, exactly. … I have lived that experience or that rejection from people because they see that am Latina then they put up a barrier of rejection. They may not want to serve us at a restaurant or may not even want to look at us."

Racism at work

Twenty-six percent of the women reported experiencing and witnessing racism at work. The most drastic cases of racism were perpetuated against the women by using their legal status against them. Liliana (34) had a very stressful job at a bakery. For example, Liliana, shared that she could receive a warning if a product like milk went bad, and since she and other employees had to use milk when baking near the oven, the milk could easily go bad. This was an intimidation technique because with any other warning the employees could be fired. In the following quote Liliana describes the stressful conditions of her job:

> "In jobs more than anything. In jobs sometimes they humiliate you because you don't have papers, they don't give you work. There are a lot of places where they don't give

you work because of that. … Sometimes one of our supervisors yells at us… the other day, she told us that because we were Mexican, and since we did not have papers, that they cold do anything but we could not. … Work is very stressful. I work a lot. And as I tell you, we have to tolerate everything the managers tell us."

As illustrated in Liliana's case, being undocumented facilitated discrimination and impunity at work. Similarly, Laura (38) worked at a restaurant for an entire month (seven days a week) but she was not compensated. After the first 15 days, she was told that she needed to leave that money as a deposit and at the end of the month instead of being paid, she was told that she could no longer work there because she was undocumented. Overall, women were aware of their lack of power in abusive work settings (in terms of unfair treatment), and the impunity their employers enjoyed. Some women, since they could not change their immigration status and could not do anything about the discrimination at work, they had accepted their situation in order to keep working and providing for their children.

Counter to experiences of racism in work settings, roughly two women had never experienced racism at work. However, they acknowledged being aware that racism at work was an issue for Latinos. One of these women worked for a White person as a babysitter and cleaned other White persons' houses. She indicated that she was always treated well by her employers. Similarly, Ana (39) shared the following, "Look, thanks to God…I've been living here for I don't know how long and they have never made a racist comment that is directed towards me. And they have never treated me less. Thanks to God, it has never happened."

Law Enforcement and racism

Three women described racist encounters with law enforcement. Examples included intimidation tactics such as threatening to deport the women. The following illustrates these experiences:

> "One time when I got in a car accident and the cop had my [Mexican] identification card. And well, he asked me why I did not have a [U.S.] driver's license and he knew that as a [undocumented] Mexican I could not have one. I started to explain that I did not have one because they would not give it to me. But he told me to shut up" (Rebecca, 25).

Monica (33) described an encounter with a cop one time when she called 911 after her teenage daughter was not coming home late at night: "…the cop was a little racist because he asked me if I was from here. I told him that I wasn't. Then he said, 'the next time you call about your daughter you are gonna go to jail and your daughter to a juvenile jail." Similar to Monica's experience, another woman called the police and was threatened by the same officer who indicated he would take her to jail the next time she called. The officer stated her husband was drunk and was playing loud music. Overall, these racist interactions the women had with the police caused fear, intimidation, and stress.

Racism from multiple ethnic groups

Several women described experiences of racism being perpetrated from Whites, Blacks, and Latinos as well. Silvia (29), after a year of living in the U.S., was aware of the notion of being disliked, "I think that Whites and Blacks see us as, because we're Latinos, they see us as being a little less. Like, oh they are not from here, they are immigrants." Sandra (46) described interracial tensions and dislike between Blacks and Latinos at work: "For instance, I work with a lot of Black people and I have noticed that they don't like us because we are Hispanic. … Then, I

think, well am not asking for anything that they don't have rights to. They always feel as if the country is theirs and all the rights belong to them."

Women described intragroup racism occurring in different settings (e.g., social service offices, at restaurants) and being spread even through the radio. For example, Lucia (46) indicated that "actually on the radio, our own people, Latinos [say] that we came to take advantage of this country, that we want to ask for papers and that we want to live off the government." The intragroup racism (from other Latinos) for some women were connected to their experience of being first generation immigrants and not speaking English. For instance, Monica (33) noted that "In the food stamps office, there were some racists, they were Hispanic and racists." She was referring to the interpreters, ignoring her, being rude and yelling at her, among other negative experiences.

> As Lucia and Monica, other women shared overt manifestations of intragroup racism: "Yes and from same Hispanics sometimes because they are born here or they were raised here, and among ourselves we treat each other. Um for example, one time we went to a restaurant… and they [other Latinos] were looking at us like "what are you doing here? You Mexican. … I feel like there a lot of places where they see you and they say 'but what are you doing here? You are Mexican or wherever you are from, simply because you are Latino" (Gloria, 33).

Family Resilience/Protective Factors and Depression

Two family resilience themes, family schema and family patterns of functioning, were identified as protective factors for depression. Family schema included women's worldview and identity as a result of being mothers. Religion and cultural values were also part of the family schema theme. Relational wellbeing was characterized primarily by social support. The main

sources of support were the partners, extended family, and girlfriend support. The themes and their corresponding sub-themes are described next.

Family Schema

Children as Strength and Motherhood

All fifteen women shared at length about the many ways in which having children and being a mother helped them deal with, cope, and conquered depression. Given the richness of the data for this theme, three subthemes emerged: (1) children as strength and motivation, (2) mothers as role models, and (3) mother identity.

Children as strength and motivation

Women described their children as their inspiration, motivation, source of strength, and the reason why they are still alive. Two women who had previous suicidal thoughts shared the following:

> "…although sometimes I wish I could forget everything, no, I have my daughter and I have to keep going. … [She] is a very strong force [in my life] because, to put it this way she was the left over; she was the last one. At some point [in my life] I didn't think I was going to have another child. But I think, if I didn't have my daughter, I don't know where I would be or what I would be doing. The best thing is that she is with me so that I stop myself from so many things that I could do being by myself" (Lucia, 46).
>
> "…Because, I, for a while, I wanted that. It was in my mind. But that was one the days when I said 'no, am not going to die because if am dying and my children are suffering, how am going to leave them? Am going to finish killing them.' And no, that's why I tell you that one has the control." (Gloria, 33)

Children were women's main reason for fighting off depression. The following two quotes illustrate how women battled and resisted depression:

> "… Last year the youngest one fell into depression and so did he [my oldest child]. And I almost fell into depression too, but I said, if I fall [into depression], who is going to take care of them? … I found strength that I don't know where it came from; it was because of my sons mainly. I say that a mother always keeps going for their children. Always, always because of them. Like that, a mother gets cured for her children. And that's what happened to me." (Ana, 39)

> "Sometimes I feel like tired, I don't want to get up, I don't want to know [pauses] of my baby, the little one [a year old], sometimes I ignore her. … I get very depressed, I have had depression symptoms that, like I don't want to do anything. I don't want to eat, I don't want to do anything, but then suddenly I get like, I have to get up, I have to start cooking for my children [7 total]. I have to put in me the batteries and I get up, and I take a shower. … The strongest motivation is my children." (Monica, 33)

Mothers as role models

Some women avoided showing signs of depression in front of their children, as these women wanted to stay strong, and avoid showing signs of weakness.

> "My day off [work], I dedicate it to my daughters … and that's something that helps you because sometimes all you do is think about you. You are not thinking if your daughters suffer because of how they see you, you don't think if your daughters cry when you cry. You don't think if your daughters say "my mom is going to die from this or that" and you are worrying them, if you are creating a trauma for them. I don't think that's the best way [to raise them] because what if they think, "oh my used to get this way, that must be

normal. My mom used to cry over this, then that must be normal.' Instead of leaving them good fruits, good teachings, you are going to leave them your tragedies." (Gloria, 33)

For Gloria, spending time with her daughters was not only a coping mechanism to but a way to conquer depression and promote a healthy relationship with her daughters. In Rosa's case (39), she was concerned about the behavior she modeled to her children through depression:

"More than anything because of the children, because they are small and am not going let them see me like that, to see that am falling and also because it's not healthy. That is what gives me strength to keep going, it's them. … I don't need to tell myself anything [when am depressed] all I have to do is look at my kids (laughs), that's more than enough."

Mother identity

Women thought of the rest of their children as a reason to try to be well when one child's behavioral or health problems were overwhelming. Adriana (30) noted, "I try not to pay to much attention to her [my daughter] to not feel depressed, to not feel depressed because I have more children. Because of [my] children I try to stay strong." Women's identity as a mother and their relationship with their children were key to women's well-being. Irma's case (41) illustrates how much value mothers placed on their relationship with their children. Irma was very affected after losing contact with her teenage son during her divorced from her abusive husband. After the birth of her newborn, Irma re-established contact with her son and introduced her son to the newborn. She used her newborn as a means to reconnect with her son. Her plan worked, as her son was very excited because he always wanted a sibling. Her newborn reunited Irma with her son.

Religion, Spirituality and Faith

All of the women in the study described religion, spirituality, and faith as important sources of resilience and support in the face of depression. The following two subthemes characterized this theme: (1) religion and church support and (2) faith and spirituality.

Religion and Church Support

Several women (n=6) described religion and the church as a critical source of support, encouragement, and strength, in particular when dealing with depression. Sandra (46) described the church as an important source of strength:

> "I go to church a lot. Um, always when am depressed my pastime is in the church. Because I feel that [he] has always been with us, because [he] always opens pathways. … When I come out of that church, I come our renewed. When I was in that terrible depression, I went to church everyday even if it was raining. I would take my kids and go to church. And honestly, I believe that had it not been for that I would not be here. Because the truth is that it was terrible [being homeless] and that I don't wish that upon anyone. … The entire time I would say 'you can do this, you can do this.' I am worth a lot and God loves me a lot. God loves me and I know he has not abandoned me and he's always with me."

Some women found guidance and support from the priest or pastor while other women benefited from church related activities:

> "I've been doing church projects. …You feel good because you have your mind busy [and you think] tomorrow am going to do this and tomorrow am going to do that activity over there. And like, you have all your [mental] space occupied that you don't have time

to think about silly things. …If God wasn't with me, then I don't know where I would be because I would not be who I am now" (Gloria, 33).

Faith and Spirituality

About two thirds of the women described faith and spirituality as a key source of strength in their lives. This subtheme was different from the previous one because the women referred to a one-to-one relationship with God, and noted their faith and individual practices like prayer helped with depression, unlike the previous subtheme where women noted the church, the minister or priest, and religious practices, such as attending service or other group activities as the sources of help. For instance, Liliana (39) noted the following, "I by myself [referring to the lack of support from other sources], I go to church and I pray and it [depression] passes. In Ana's words,

> "People who believe in god, draw strength from that too. Strength. … When am overwhelmed with so many personal problems, what I do is grab the bible and start praying and helps me to keep going. Prayer has a power that you cannot imagine. I'm not religious; I don't have a religion per se. … Prayer and faith; people without faith are nothing." (P11)

In the following quote, Jimena (30) explained the power she draws from believing in God,

> "Religiously [I say that] God takes us out of any depression. As I tell you, simply by praying and seeking after him because otherwise, who knows what would be of my life? I feel good going to church. …I have never done things like drinking or going to bars. Thus, I feel that God has helped me a lot."

A lot of the women described prayer as an important coping mechanism:

> "When I need prayer, I have a lot of faith so I go to her [mom's friend, a very religious person]. She comes over to see me and we talk and she prays for me" (Lucia, 46).
>
> "When I have problems or things like that … I pray and I say to myself 'It's not your fault. Keep trying and if this does not work lets look for the solution and if there is no solution then there is no point on me crying. All the tears that I shed are not going to fix anything" (Sofia, 33).

As with prayer, women referred to reading the bible as a helpful coping mechanism.

> "Mhm, yes when I get like that [depressed], I have my bible and read it, that relaxes me quiet a bit, and it helps a lot. And I do that and that helps me to take ideas off my head for my own good" (Monica, 33).

Ethnic Identity as a Cultural Value

Only a third of the women shared phrases or sayings (dichos) that they believed provided hope or strength when facing depression. Such phrases represented cultural values and norms. Some women, however, did not note any phrases as a source of inspiration or as a coping mechanism. Not surprisingly, given the strong influence of religion in Mexico, most of the information shared regarding this theme was in reference to religion, in particular God. For instance, Julia's (39) saying was, "As they say 'God is not going to give you something that you cannot withstand'." Similarly, Lucia (46) shared the following: "Today, as I told you a moment ago, today I feel bad but tomorrow I will feel better. It's not a saying, but we us 'God squeezes but does not strangle'." One very religious woman, Laura, did not share a particular saying that was specific to coping with depression; however, she did share different personal examples and religious stories.

The stories illustrated the value of maintaining a positive mindset when dealing with problems. She noted that, "you have to see the whole the picture." Laura believed that by seeing the whole picture then she was able to make sense of why things happened.

A couple of the non-religious sayings were: **"**first comes the storm and then calm" (Silvia, 29). The following quote by Gloria (33) provides more insight into how beliefs or perceptions about one's racial ethnic group can be used,

> "Oneself closes doors and says 'Oh no, this is my last, this is all I can handle.' I think that as Latinos, supposedly it's said that we are harder working, more this or more that. You don't have to give up the first time. You have to keep going, keep going, keep going despite feeling that your world is coming to an end, it doesn't end. You feel that, but it does not end."

Gloria was the only participant who provided a more nuanced and elaborate response to sayings that she used to help herself through depression.

Patterns of Functioning

Social Support

Two thirds of women (n=10) had either nuclear family support from their partners or extended family members. The majority of the women who had partners also reported support from extended family members including mothers, fathers, and siblings. An important phenomenon for the women in the study was the transnational nature of their families, mainly regarding extended family members—parents and siblings (however, two women had sent their teenage boys to live in Mexico). Despite overall high levels of support, five women described low or no support from family members. Overall, these women's narratives highlight the nature of support as a process influenced by relationships. Given the nuanced descriptions of family

support, four subthemes are covered: (1) nuclear support: partners, (2) extended family support, (3) transnational families, and (4) low family support

Nuclear support: partners

The majority (seven out of ten) of women who had a partner or who were married described their partners as generally supportive. Several women described their partners as supportive only in regard to helping with the children's and working hard. Other women, like Ana (39), highlighted their partner's support as a key source of support when facing a crisis—their children chronic health problems. When one of Ana's children became sick and was bound to a hospital bed, she described her partner support as follows, "my partner helped me a lot. We got together before my kid got permanently sick. [My partner] was in the hospital with me [when my kid was hospitalized]. Those were difficult days. He went to work and then to the hospital." Only a few women explicitly described their partners as support sources when dealing with depression. Rosa (39) in the following quote shares her husband's support regarding depression:

> "My husband has always been there. Always, when he sees me sad, he tells me 'no, we have to keep going' And more than anything else because of the kids because they are small and am not going to allow them to see me that am falling. And also because is not healthy for them to see me like that."

Extended family support

The majority of women (n=8) felt relieved by sharing their troubles, stresses, and worries with extended family members. The women noted that sharing with others helped feel relieved. Women often cited their extended family members including mothers, fathers (usually in the absence of mother), sisters, and sisters-in-law as family support. Extended family support was mainly provided by other women, except for a couple of women who also described their fathers

as a source of support, and one woman mentioned her brother as an important source of support. Similarly, only one woman described her uncle as a part of critical extended family support in her life. The majority of women listed several extended family members as sources of support. For instance, Sofia (33) noted, "I also have a lot of trust in my uncles, my mom's siblings, with my sister and my sisters-in-law. I think that mainly [what helps] is to not keep in that feeling in." Like Sofia, other women received support from several extended family members when they most needed both emotional and tangible support. Family support was critical when women noticed depression symptoms back in their lives:

> "I get very hungry, [and I eat] more so carbohydrates, and also I want to drink. I drink socially, I mean, I do drink but in those moments [when I get depressed] I want to lose myself [in drinking]. But I don't, I try to pull myself up or sometimes I call my sister and she listens to me, I cry and she gives me advice. Or I call my dad [mother passed away]. … She [mom] was with me every year for three months and she was main support. It wasn't my sister or my dad; it was my mom. Then, as a result of that [her death], more depression. I had to learn to trust my sister because I didn't have the same trust even though I had some close to me to talk to. Since I don't have a partner, someone close to me who I trust, only her [my sister]" (Lucia, 46).

Lucia's quote also illustrates the duality of support and family relations when a person relies mainly on one family member for support and the effect of losing that person. The women's mothers played a significant role in supporting and advising them through difficult situations. Some women had vivid memories of advice from their family, in particular from their mothers. In the case of Silvia (29), as illustrated in the following quote, her mother's advice helped her act and find agency when she was feeling hopeless.

> "Some of the words that made me react and say no! [was], one of the biggest things when their dad wanted to take my girls away and send me to Mexico [after a year of having arrived here with my daughters]. … I remember the last time I called my mom [in Mexico] crying, and I told her "Mom, he's going to take them away from me. I can't do anything, am in the United States. Even if I call the cops they will not understand me. He tells me that if am not with him they are going to take me out of the country. … Then I remember my mom's words, she told me 'here, in China, or wherever you are, they are your daughters, you gave birth to them and you endured that pain. You come back here with your daughters, or you don't come back. Because once you leave the US, you will never see your daughters again.' That was like a wake up call and I said that's true! … It was there where I found strength and I said no. You are taking my daughters? You are not taking anything!"

Transnational families

The majority (86%) of the women had extended family in their country of origin and many maintained long distance, international, family relations. Such relationships were particularly important given that many of the women in the study noted their immigration status, which denied those who were undocumented to visit their families in their home country. Several women described important support from mothers and sisters who were in Mexico. For instance, Irma (41) despite not feeling supported by her mother, receives advice and support from her sister in Mexico,

> "I don't [have support] from my mom, I have a relationship with her, we converse, we don't fight but I don't feel that she's supportive. I don't know why, maybe if I asked for support I could find it. My sister is supportive, she lives in Tijuana [Mexico] but

whenever we talk on the phone she's always supportive, always. At least over the phone, she tells me, she calls, she gives me advice up until today [15 years after I moved to U.S.]."

Gloria (33) painted a more mixed picture of extended family support involving family members both in the U.S. and in Mexico. In the following quote, she described valuing psychological support versus proximity to family members who were unsupportive:

"My mom is in Mexico, but sometimes calling her helps a lot. Despite not having them physically, [having them] psychologically helps a lot. I think that's the most important sometimes because it is of no use to have them [family members] here. I have a brother who I see, I believe, I don't know, once a year and I have him physically [close], but not psychologically. Thus, I think that it's more important to have them psychologically than physically."

Low family support

Several women described little or no family support from any source. One third of the women who had partners did not receive support from them. Two of these women also did not receive family support (in part because they did not want to ask for support). In Rebecca's case (25), she said "no [my family does not support me] because am one of those people who do not like to share. I prefer to keep it to myself. Sometimes it does not help because one does not vent." The other woman, Liliana (34), had a partner but they had marital problems. She also indicated that she had no support, not even her mother as she explains in the following:

"Well, I have never liked to tell my mom [whose in Mexico] my problems from over here. I always tell her that am well even when am not. Even when I have problems here, I never [share them]. I always tell her that am well and that everything is fine because I

don't want to worry her. Because I don't like anybody worrying about me while I have my worries inside."

Similar to Liliana, Sandra (46)—when she was temporarily homeless, had marital problems, and had no support from her partner. She also did not count on her extended family. Even when she desperately needed financial help she did not ask because she noted, "I have family here but I don't share nothing with them because since they are well, economically, they only criticize."

Girl friend support

Several women (40%) had general and emotional support from female friends. This source of support was key for the women who had no family support. For instance, Rebecca (25), who dislikes sharing with her family, was able to find support in her friend. She noted, "… but I do have girl friend, a very good friend of mine who I share with when I really need to." Lucia (46) considered her best friend family, as she explains: "My girl friend, am very thankful for her because in reality I consider her my family because I have family here who have not supported me in anything. She is the only one who has been with through everything with me." Three women, however, did not have support from girl friends. These women did not trust other women; in Monica's (33) words "I actually have no girl friends because there are no girl friends." Overall, unlike family support, women shared very little about friend support.

Summary of Qualitative Findings

Risk Factors

The thematic analysis revealed five main risk factors for depression: (1) children's health, (2) family conflict and stress, (3) financial strain, (4) gender oppression, and (5) racism. Not all of the women described all five risk factors as direct or indirect influences of depression, but the majority of women described more than one risk factor. All of the women were mothers and

some of them had children with chronic health conditions that had become stressful and overwhelming, which contributed to the women's depression. Family conflict and stress including marital problems, losing relatives, and ending relationships resulted in women feeling unsupported and isolated, which resulted in women experiencing depression.

Financial strain was a compounding stressor for women; this was no different for single mothers or married women. Women described clear linkages between domestic violence and depression, as well as between sexual abuse and depression. All of the women with severe experiences of abuse and trauma, even years or decades later, experienced recurrent depression. The majority of the women had experienced or witnessed racism; women described such experiences as frustrating and sometimes stressful. However, none of the women described discrimination experiences as a direct influence on depression. Based on the women's narratives, the strongest factors associated with depression were abuse, trauma, financial stress and overwhelming situations because of their children's chronic health conditions.

Protective Factors & Family Resilience

The main two family resilience themes described in women's narratives were family schema and patterns of functioning. Three components characterized family schema: women's children and women's mother identity, religiosity, and cultural values. Women described their children, identity as mothers, and religion or faith as critical sources of strength and encouragement when facing depression. Regardless of the circumstances, women described their children as motivation, strength, and the reason to keep going or get better during depression. Ethnic identity as a cultural value was not commonly described as helpful in coping with or overcoming depression. Patterns of functioning, the second family resilience theme identified, included different sources of support such as partners, extended family members (some of which

were in other countries), and girl friend support. These sources of support were salient in helping women cope and adjust, and sometimes buffered against depression. Women's descriptions of family support also included encompassed of family relations, family dynamics, and functioning. For some women, family support was key during and after depression. Also, the women's stories revealed that lacking partner or extended family support made them more vulnerable to depression.

CHAPTER 5: DISCUSSION

Discussion—Study 1

Risk Factors

Financial Strain

Financial strain had a significant association with depression as revealed through the Chi-square test; however, in the logistic regression it was not a significant predictor of depression. One explanation for these results is that another intervening factor such as stress (resulting from the financial strain) may help explain the relationship between financial strain and stress. Thus, a third or mediator variable could shed light on this finding. Another explanation is that the relationship between finances and depression should be re-specified to assess whether low financial strain, or having a surplus amount of money, predicts depression. Besides these methodological issues, some other measurement observations are in place such as (1) the measure may not be the best measure of financial strain, and (2) other factors may be more important predictors of depression than financial strain for this population. The literature, overall, highlights the negative role of poverty and other measures related to socioeconomic status (SES) and mental health outcomes (M. Alegría et al., 2007; Belle & Doucet, 2003). However, the relationship between poverty, SES related measures, and depression is more complex than originally proposed. In a study of Mexican-heritage mothers, Marsiglia et al. (2011) found that poverty was not associated with depression, while education was significantly associated. Overall, more measurement and methodological considerations should be given to studying social disadvantage and depression.

Perceived Discrimination

Women who reported high levels of perceived discrimination were more likely to also report depression. This finding is consistent with previous literature that has reported negative mental health outcomes as a result of perceived discrimination (Pascoe & Smart Richman, 2009). Although the congruence between the present study and other studies is important, it is noteworthy to mention that overall the relationship between discrimination, including racism, and depression is inconsistent (M. Alegría et al., 2007).

Family Cultural Conflict

As expected, family conflict significantly predicted depression in Latina women. Family conflict had the strongest association with depression compared to financial strain and perceived discrimination. Not surprisingly, family conflict was also a stronger predictor of depression than perceived discrimination. Family conflict as a predictor of depression has consistently been found in other studies with Latinos/as (M. Alegría et al., 2007; Ornelas et al., 2009). The role of family conflict in predicting depression is also highlighted when considering cultural values that are important for Latinos, such as familism, respect, and personalism. These cultural values emphasize interpersonal relationships (Bermudez & Mancini, 2013).

Protective Factors

Religion and family wellbeing were studied as potential moderators between risk factors and depression. However, neither religion nor family well-being were predictors of depression. Women with low levels of religion were as likely as those with high level to experience depression. Furthermore, both family resilience constructs were not moderators of the relationship between risk factors (family conflict and discrimination) and depression. Other studies that have examined whether religion predicts depression in Latinos have also reported

that it does not (M. Alegría et al., 2007). The present study used a measure of religion (seeking comfort in religion during difficult times) that seemed more relevant to depression than reporting on the frequency that someone attended religious services (M. Alegría et al., 2007); however, the results were the same. Thus, the role of religion in mental health should be re-examined.

The relationship between family well-being and depression seems to be more nuanced than the relationship between religion and depression. For instance, religion was not associated with depression in the Chi-square test, it was also not predictive of depression in the logistic regression (test of main effects), and it was not a significant moderator. Family well-being was significantly associated with depression in the Chi-square test, but it was not a significant predictor of depression and it was not a significant moderator between discrimination, family conflict and depression. Given the inconsistent results between family well-being and depression, it is possible that other variables could explain this. Another potential explanation for these results is that family well-being and depression may have a bidirectional relationship, meaning that depression may also predict family well-being.

In the literature a similar construct to family well-being is family cohesion. One of the few studies that has examined the relationship between family conflict, family cohesion, and psychological distress reported a significant association between family cohesion and psychological distress (Rivera et al., 2008). This association, however, was not consistent across Latino groups. Another concept related to family cohesion is acculturation; studies have found that low acculturation is related to high family cohesion or that immigrant families are highly connected (Miranda & Matheny, 2000). Overall, the role of both ethnicity and acculturation are important when studying family cohesion and mental health outcome for Latinos.

Methodological Considerations

Given the nature of the data (secondary data analysis) and the relationships examined, a brief methodological discussion is presented here. First, it is important to discuss the 12% rates of major depression found in the present study. NLAAS is one of the few and most recent population-based studies that offer prevalence rates of major depression for Latinos. The National Comorbidity Study (NCS) reported lower (6.7) rate of major depressive disorder in the previous year for English speaking adults (Kessler et al., 2005). Although the NCS cannot be directly compared to NLAAS regarding Latinos' rates of major depression, both studies show that 12-month major depression affects less than 10 and 15 percent of their respective population. The role of ethnicity should also be noted. Consistent with U.S. population demographics, Mexican women were the largest Latino group in the present study and in the literature. Mexicans also reported lower rates of major depression than other Latino groups (M. Alegría et al., 2007).

Other potential measurement and conceptual explanations were presented above regarding financial strain and family well-being—which has a significant association with depression but does not predict depression. Methodologically, these results could also be related to the poor classification observed in the logistic regression models (this issue was noted in the description of the first logistic regression model in the results section). The logistic regression models, despite the number of predictors in the model, did not classify any of the depressed women as depressed. The classification for the non-depressed women was not an issue; all 88% of non-depressed women were correctly classified. Tabachnick and Fidell (2013) described classification issues because of poor predictors (e. g., risk factors). They also noted that SPSS classifies cases into the category with the highest probability (in the present study this was non-

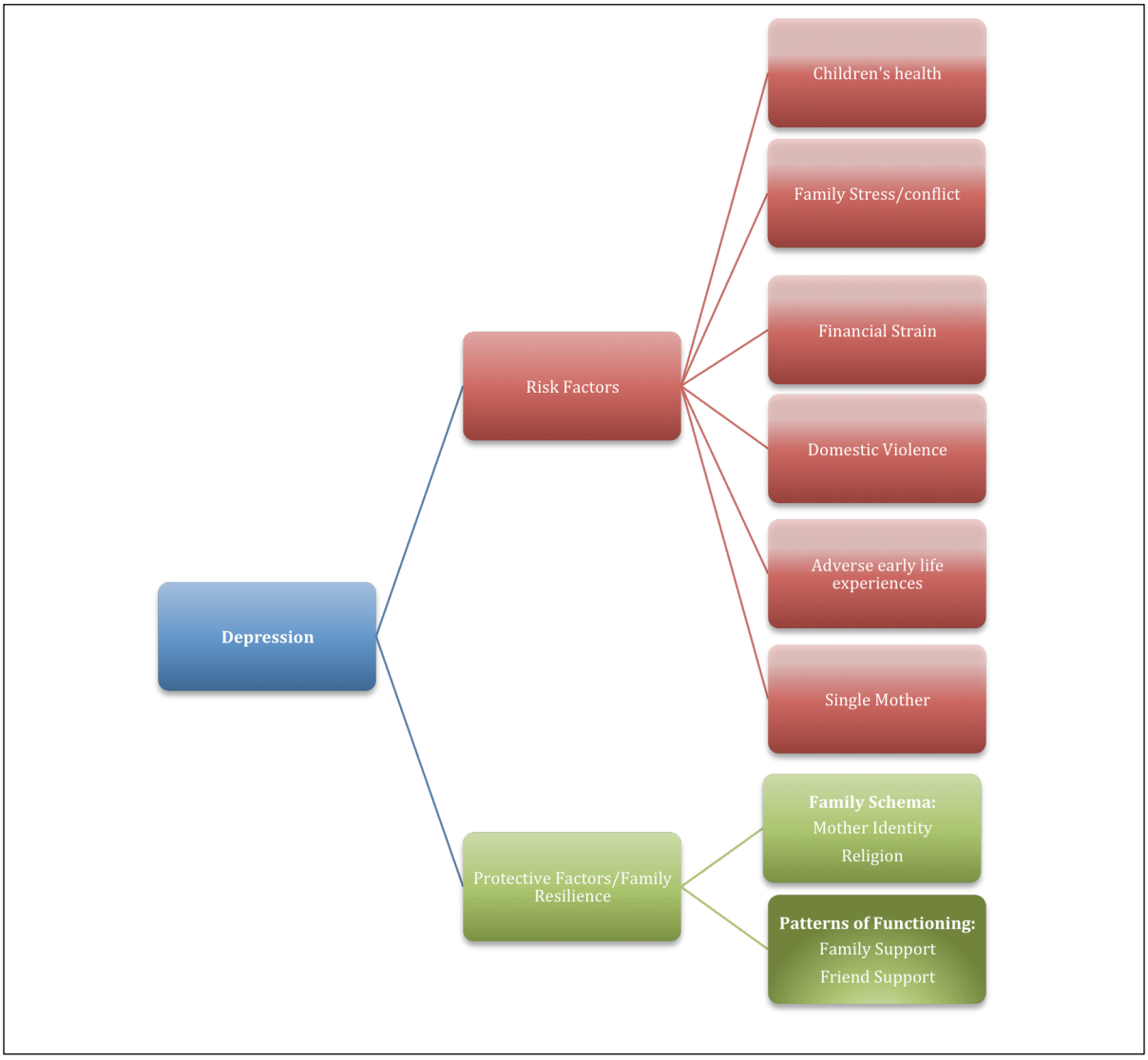
depressed group). The last methodological issue discussed is about analytical considerations when examining moderation. Frazier, Tix, and Barron (2004) described a set of factors that affect the power of testing interactions. Although their discussion applies to multiple regression analysis, some of the key points they described are also relevant to the present study. For instance, they noted that moderation analysis has more power to detect a significant interaction when the predictor and outcome are strongly related. Frazier et al. (2004) described power issues for categorical variables when the groups have unequal sample sizes.

Discussion—Study 2

Consistent with previous literature, the Latina women in the study reported family-based, sociocultural, and financial conditions as factors that directly or indirectly lead them to depression. The women's narratives of depression also were characterized by family resilience, including family schema and patterns of functioning. The risk factors are described first in this section. Findings regarding both risk and protective factors (resilience) are discussed and integrated along with existing literature and family resilience theory. Figure 3 illustrates the risk and protective factors that women described in the context of depression. According to risk and resilience literature, risks include drastic changes, events or crisis (e.g., a child with cancer, immigration) that would create demands and stressors above and beyond the individuals' capacity and resources (Masten & Coatsworth, 1998; Masten et al., 1999; Schoon, 2006; Ungar, 2003). In the present study, the main risk factors described by women included high levels of family stress, financial strain, gender inequality and oppression in the form of domestic violence and sexual abuse. Similar to other research, these risk factors became stressful experiences (Contrada et al., 2000; Flores et al., 2008), and when the stressed piled up, it resulted in depression. In line with risk and resilience literature, the pre-existing conditions negatively

affected the women's mental health resulting in depression. Thus, in the context of mental health, depression was the byproduct of extreme events and crises.

Figure 3. Qualitative Findings



Risk Factors

Violence, Trauma, and Depression

Although no formal depression instrument or diagnosis was used in the interviews, based on the women's descriptions, they all had experienced depression symptoms in the previous

year. Some of the women were currently experiencing high levels of distress, given that they shed tears when speaking about basic things such as how many children they have or their work. These "basic" topics triggered an emotional reaction in the women (they became visibly upset) because of their current circumstances. The women who described severe domestic violence or childhood sexual abuse, also made clear connections between those experiences and their current struggles with depression. In fact, they shared their experiences of abuse and trauma when talking about depression. This finding is supported in previous literature that highlights the relationship between domestic violence and negative mental health outcomes (Bonomi et al., 2006; Caetano & Cunradi, 2003; Coker et al., 2002). This relationship has been documemted for Latina women as well; Latinas who experienced intimate partner violence report high rates of depression (Caetano & Cunradi, 2003). Similarly, researchers have reported on the association between adverse early life experiences (e.g., childhood sexual abuse) and negative mental health outocmes (Koplan & Chard, 2015). Cumulative trauma affects the intensity and simultaneity of clinical symptoms for women (Briere et al., 2008; Chemtob et al., 2011; Cloitre, Cohen, Edelman, & Han, 2001; Jenkins & Cofresi, 1998).

Family stress and depression

The two main sources of family stress and problems for women were family relations and children's health. Women described becoming single mothers as a negative and sometimes difficult context of their lives. Women who had been single mothers for years also highlighted their experiences as single mothers as contributing to their loneliness. Overall, women's experiences as single mothers were captured throughout other themes. Consistent with previous literature, being a single mother is associated with depression (M. Alegría et al., 2007). The other main source of family stress was children's physical and mental health, as well as behavioral

problems. Women who had children with chronic health conditions such as muscular dystrophy or epilepsy reported that these life changes as overwhelming and direct influences on their depression. Besides that, some other women struggled with their adolescents' behavioral and psychological problems, which created parental conflict and also disrupted other family relations.

Finances and depression

Income was not directly assessed in the present study; however, women provided in-depth descriptions of the main indicators of socioeconomic status such as education and employment. Additionally, central to the women's narratives of depression were stories of financial stress and struggle. Research has consistently shown that women are at higher risk of living in poverty, living off welfare, and experiencing harsh living conditions that may result in depression (Belle & Doucet, 2003; Hays, 2003; L. Smith et al., 2012). Other studies have reported that Latinos/as who were unemployed, perceived to have low social standing, and perceived low neighborhood safety, were at risk for 12-month depression (M. Alegría et al., 2007). In the present study, lack of financial resources caused two women to become homeless and another to lose her house. As noted, these women indicated that this was one of the most difficult times of their lives. Overall, the majority of women had ongoing financial struggles. Also, financial stress was commonly described along with other risk factors.

Discrimination, Microaggressions, and Depression

The majority of women had experienced overt discrimination or racism and only one of them described microaggressions. All of the women had immigrated to the U.S., and many of them shared their discrimination experiences, which stemmed from their immigration and legal status. Consistent with the literature on discrimination among Latinos (Bonilla-Silva, 2003; Parra -

Cardona et al., 2006), women in the present study also indicated that they experienced discrimination because they were non-English speakers.

Despite discrimination being shared as a common experience by women, only one woman linked those experiences to depression. The participant, with a severe case of discrimination, described her work as very stressful and filled with intimidation techniques because she was undocumented. Only one woman described both overt and covert experiences of racism, based on her detailed descriptions of such experiences it became clear that she had a nuanced and more insightful understanding of race relations. Although this woman had a more advanced understanding of discrimination and had experienced discrimination in different settings and by different racial/ethnic groups, she did not associate these experiences with depression. Other studies have reported that relationship between discrimination-based stress and mental health outcomes is incongruent (Paradies, 2006; Pascoe & Smart Richman, 2009). Thus, as a whole, the findings from the present study contribute to the literature, which also has reported a lack of relationship between discrimination and negative mental health outcomes.

Intersectionality

Overall, women's intersecting identities (i.e., being a woman, a mother, divorced or separated, low income, and immigrant) and the experiences that resulted from such identities create a pile up of stressors and emotional problems. All of the women described overwhelming situations and crisis that led to depression as a result of experiencing challenges and stress from more than one of their identities. Despite gender comparisons not being possible from the present study, based on the women's stories, it could be inferred that for women, a combination of factors such as experiencing abuse, trauma, and overwhelming situations—as a result of their mother caregiver role, make women more vulnerable to depression than men.

While a study comparing these risk factors and depression between men and women would elucidate this point, research has documented that women are the main target of intimate partner violence perpetrated by men (Tjaden & Thoennes, 2000). The prevalence rates for rape and sexual abuse also are higher for women than men (U.S. Department of Justice, 2010), and the social and cultural norms expect women to serve as the primary caregivers of children. In the Latino culture familism (valuing the family above all) and marianismo (self-sacrifice for others, in particular for their children) are two cultural values that help enforce tradtional gender roles for women (Castillo, Perez, Castillo, & Ghosheh, 2010). In the present sudy, women's identities coupled with cultural expectations and traditional gender roles negatively affected them. For instnace, three women described a desire to leave their partners but decided to stay in the relationship because of their children. These were strategic decisions since the women noted that they did not want their children to grow up without a father. The women also noted the stigma associated with being a single mother in the Mexican culture.

Protective factors: Family Resilience

Findings from the present study identified two (i.e., family schema and patterns of functioning) of the three family resilience themes proposed by family resilience scholars. Two family resilience frameworks guided this study: (1) the Relational and Resilience Theory of Ethnic Family Systems—R&RTEFS—(L. D. McCubbin & McCubbin, 2013) and (2) Strong Families (Bermudez & Mancini, 2013) a similar framework to R&RTEFS but specific for Latinos/as. These frameworks highlight three major family resilience themes: (a) family schema, (b) patterns of functioning, and (c) relational well-being. Family resilience is a dynamic process by which families respond, adjust and adapt to a crisis or overwhelming accumulation of stressors (Antonovsky & Sourani, 1988; Hawley & DeHaan, 1996; H. I. McCubbin et al., 1993;

Patterson, 2002; Walsh, 2003). The next sections discuss the family resilience findings in light of the two family resilience frameworks.

Family Schema

Family schema involves a family's shared values, goals, priorities, expectations, and worldview—which serves to process and evaluate events and experiences (H. I. McCubbin et al., 1993; L. D. McCubbin & McCubbin, 2013). Consistent with family schema, women in the present study described their children and their identity and role as mothers as the strongest source of strength, motivation, and inspiration when battling depression. Other studies also have reported that children are women's motivation for the future, and that Latinos describe parenting is salient in their lives (Campbell, 2008; Parra‐Cardona, Córdova, Holtrop, Villarruel, & Wieling, 2008). In the present study, women who experienced recurrent episodes of depression, as a result of abuse and traumas that occurred in the past, also described their children as the reason why they fought against depression. Although two cultural values, familism and gender roles, were described as risk factors in the previous section, these cultural values also seem to facilitate family resilience. Other studies also have reported familism and gender roles as characteristic of women's resilience (Cardoso & Thompson, 2010; Mogro-Wilson, 2011).

Several women had contemplated suicide, but they made no attempt to end their lives because of their children; they knew that their children needed them. Regardless of how women felt and regardless of other stressors (e.g., work, finances, marital and relationship problems), all of the women described their children as their priority and focus, and the reason why they continued. This translated into women continuing to work and carry on their daily activities, which is counter to a key aspect of diagnosing clinical depression. A clinical diagnosis of depression includes an assessment of the level of interference depression has in the "functioning"

or daily activities of a person (DSM-5, 2013). Thus, the finding from the present study questions the cultural and contextual relevance of mainstream diagnoses of depression.

Faith & Religion

Bermudez and Mancini (2013) described religion as an important aspect of Latinos/as resilience because of the community connections and social support, resulting from participating in the church. In the present study, all of the women shared about the importance of religion, faith, and spirituality when facing difficult situations, including depression. Religion was the second most common source of resilience for women. Some of the women described church attendance and other church related activities as helpful; however, over half of the women described faith and their personal relationship with religion through prayer and reading the bible as critical sources of strength. Women found solace in prayer. Some women described faith and prayer as a main coping mechanisms when afflicted with depression. Given that most women described faith and religion as coping strategies that helped them feel better and gave them strength to keep going, the concept of religion was more consistent with family schema than with social support. Overall, this finding is congruent with other studies that have reported a negative association between religion and psychological distress in women (Jarvis, Kirmayer, Weinfeld, & Lasry, 2005)

Ethnic Identity as a Cultural Value

Because of the association between ethnic identity, acculturation, and resilience, Bermudez and Mancini (2013) conceptualized ethnic identity for Latinos as an important source of resilience. However, in the present study, ethnic identity in the form of sayings or phrases that helped women through depression was only marginally mentioned. The majority of women did not use any phrases when battling with depression. Only a few women used such phrases;

however, the phrases were religious. The current study is the first study (according to the author's knowledge) to explore the relationship between ethnic identity and depression in Latina women from a community sample. On the other hand, the literature has focused on understanding the protective role of ethnic identity in Latino adults, mainly college students, who experienced discrimination (French & Chavez, 2010; Torres & Ong, 2010). Thus, ethnic identity may be more relevant for younger or college student Latinos/as whose identity is still developing and for whom acculturation is imperative.

Patterns of Functioning

Patterns of functioning (POF) are the ways in which families interact to sustain and nurture family members; these patterns characterize families based on the adaptability and cohesiveness of the family (L. D. McCubbin & McCubbin, 2013). Communication and relationships are at the heart of family resilience because of the importance of social support, problem solving, and power relations in families (Walsh, 2006). In the present study, POF encompassed social support from three main sources; (a) nuclear family, (b) extended family and (c) girl friends. Social support helped the women manage circumstances that contributed to their depression, and it also provided venues to feel emotionally supported. This finding is consistent with other studies that have highlighted family support as a key factor in family resilience (Cardoso & Thompson, 2010). One unique characteristic of the support that many women described was maintaining family relations with and receiving support from relatives (mainly parents) in their country of origin. Thus, women benefited from family support despite having transnational families.

CHAPTER 6: CONCLUSION

This dissertation used two studies with different methodologies to explore risk and protective factors of depression among Latina women. The two studies differ in methodological approach; however, they both focused on understanding how social risk factors and family resilience affect depression. Given the scarcity of studies investigating a set of risk and resilience factors for depression in Latinas, using both quantitative and qualitative methods was advantageous. The results from this mixed methods approach provided a greater understanding than if only one method had been used. Table 4 illustrates the results from both studies. As shown in table 4 there was little convergence between the studies across findings. Convergence between both methods was found for family conflict. There was no convergence for religion; in the quantitative study, religion did not predict depression but in the qualitative study religion played a key role for women facing depression. Convergence for the rest of the constructs studied is somewhat mixed. For instance, while financial strain contributed to women's experience of depression in the qualitative study, it did not predict women's depression in the quantitative study. Gender oppression was not examined in the quantitative study; however, it was a key risk factor in the qualitative study. Measurement issues that could have influenced the different results between studies are discussed next.

Risk Factor 1: Children's Health

Some women's risk factors for depression included children's physical and mental health and their behavioral problems, and in some cases those problems contributed to the women's depression episode or depression relapse. Three subthemes emerged: (1) children's behavioral and psychological problems, (2) children's chronic health problems, and (3) family health embedded in family relations. The quantitative study used a measure of depression that is

Table 4. Results from Both Data Sets

	Study 1: QUANT	Study 2: QUAL	Convergence
Risk Factors			
Social Disadvantage ▪ Financial strain	n.s.	✓	More or less
Discrimination			
▪ Race/ethnic discrimination	✓	?	More or less
▪ Gender oppression	N/A	✓	No— N/A
Family Conflict/Problems	✓	✓	Yes
Protective Factors: Family Resilience			
Religion	n.s.	✓	No
Family wellbeing	✓	?	More or less
Family Patterns of Funct.	N/A	✓	No

✓ Indicates a significant result of finding. N.s. indicates not significant. N/A indicates not applicable because the measure or construct was not included in the study.

consistent with a clinical diagnosis of depression, while the qualitative study used the women's descriptions of their lived experiences of depression. Both approaches are represented in the literature. Major depression (consistent with a clinical diagnosis) is commonly measured in

national epidemiological surveys (e.g., National Comorbidity study (Kessler et al., 2005), National Health and Nutrition Examination Survey (Riolo, Nguyen, Greden, & King, 2005), NLAAS). However, the vast majority of non-population studies in the literature use symptom-based measures of depression—psychological distress and depressive symptoms (e.g., Alamilla, Kim, & Lam, 2009; Baxter et al., 2014; Flores et al., 2008; Mendelson et al., 2008). Furthermore, researchers have explored the clinical importance of symptom-based measures or 'subthreshold' symptoms and have reported that depressive symptoms are clinically significant, supporting the study of depression in a continuum (Lewinsohn, Solomon, Seeley, & Zeiss, 2000). In sum, the clinical diagnosis approach is mainstream and psychometrically valid; however, the women's descriptions of their experiences also are as valid. Thus, both measures of depression have research and clinical implications (discuss later in respective section).

Quantitative Limitations

The quantitative study has several limitations. The study is correctional, and as a result cannot provide information about the relationship among the variables over time. The relationship among the constructs of interest may look different when examined over time. Family relations and configurations change based on the family's life stage and other aspects of an individual's development. The current study also did not examine reverse associations such as family conflict and the outcome of depression. Although some risk factors predicted depression, this does not mean that those risk factors caused depression. Lastly, ethnic differences were not examined in the present study.

Qualitative Limitations

In the qualitative study, a convenience sample limits the findings, so that the findings cannot be generalized to the U.S. Latina population. Nevertheless, the qualitative findings

extended to other Latina women with similar characteristics: first-generation immigrants from Mexico, low income, and mothers. Another unique characteristic of the women in the qualitative study is that they all had children receiving some psychological services at a community mental health services agency. The children's need for psychological help may be an indication of other family problems. Thus, it is possible that this group of women represent a subset of Latinas with high levels of family stress, high levels of violence, more socioeconomic disadvantage, lower support, and higher levels of religiosity. However, it is also possible that these women are an accurate representation of a subset of Latinos/as in the U.S.—immigrant low-income families.

Conclusions from Both Studies

Despite the overall lack of convergence between the studies and the aforementioned limitations, it is important to present overall conclusions. By using two different data sets, I was able to study similar constructs and empirically test parts of the resilience model. The findings from the qualitative study provide a more nuanced and richer understanding of risk and resilience factors than the quantitative study. Establishing statistical significance is not viable with the qualitative data, however, findings from the women's narratives provided meaningful research and practice implications (describe in the implications section). For instance, risk factors such as trauma, violence, and adverse early life experiences emerged as critical sources of depression for women in the interviews. None of these risk factors were captured in the quantitative study. Thus, more studies should incorporate both methodologies in order to provide more complete information beyond statistical significance. For instance, a mixed method sequential explanatory design could be used to integrate both methods.

The qualitative study provides an in-depth understanding of cultural values in relation to depression. For instance, ethnic identity was not described as a protective factor. This cultural

value may not be relevant to multi-stressed or domestic violence survivors. Taking into consideration women's experiences of violence and trauma, which are considered social determinants of mental health (Shim et al., 2015), ethnic identity becomes irrelevant to their women's well-being. Similarly, it is possible that women did not perceive discrimination as a factor that contributed to their depression because they had experienced other risk factors (e.g., violence, becoming homeless, children's health and disabilities) that were more threatening to their well-being than discrimination.

Implications and Recommendations

Considering the limitations described above, research, theory, and practice implications are presented. Family conflict and discrimination are significant predictors of depression in Latinas, but they did not explain much of the variation in depression, indicating that other factors could be stronger predictors. Overall, the knowledge base about risk factors and depression in Latinas is limited. Other research implications included the uneven distribution of risk factors for depression among Latinas. For instance, a combination of factors, such as low-income, single mother, and immigrant, are more relevant to a subgroup of Latinas, which are those who embody these identities, than to all Latinas. Similarly, resilience looks different depending on the family and social context of the women. Specifically, religion and family cohesion seem to be helpful for low-income immigrant women; however, the same effect is not observed when all Latinas are studied together. Epidemiological surveys also should collect data on social determinants of mental health such as adverse early childhood experiences as well as violence and the resulting trauma. Mixed methods can be used to enhance current methodological and measurement shortcomings in the literature.

Theoretical implications include the need to integrate family resilience into mental health research. One way to accomplish this is by incorporating better family resilience measures in population-base studies. Family resilience also should be measured at the family level by collecting data from key family members. Similarly, a family level assessment of mental health, in particular depression, should help inform how different family members influence each other's mental health. Studies applying these recommendations should be done using both cross sectional and longitudinal approaches. Currently, studies of family resilience theory and depression are limited. Therefore, overtime after more empirical studies of family resilience and mental health have been conducted, the leading family resilience theories should be revised and updated.

Applied recommendations are discussed in the context of clinical and health practice as well as interventions. Clinicians and other health providers (because of psychosomatic symptoms physicians can be the first health professional to detect depression in Latina women) who work with Latina women and their families should not rely solely on diagnostic tools. Latina women may not express depression symptoms based on interference with daily activities. Similarly, root causes of depression such as domestic violence and sexual abuse may be missed on screening and medical forms. It also may be inappropriate to ask sensitive questions on medical forms that may trigger emotional reactions without being prepared to offer appropriate services or referrals. These issues highlight the importance of building rapport and creating a safe space where women can trust the professionals to disclose sensitive personal information that may be related to depression. Clinicians and health professionals should be mindful of how their approach with women may fosters women's strengths and encourage resilience.

Interventions should be designed at the community level with a focus on family relations as well as integration of different sectors. Reaching women through community venues is a viable approach given that women, especially those with children, are already connected to community resources (e.g., centers, clinics, churches). The role of family problems and family relations should be emphasized when helping Latina women with depression. Interventions should be flexible in order to be relevant and suitable to different Latina groups. Given that some Latina women (e.g., suffer from trauma and violence) may require help from different mental health professionals (e.g., psychiatrists and family therapist), interventions also should connect women to appropriate services. These recommendations are consistent with other resilience researchers who have highlighted that key components of interventions should consider multiple contextual and cultural factors (Ungar, 2011).

APPENDICES

APPENDIX A: NLAAS Questions

All the NLAAS measures relevant to this study are included here. ICPSR provides the questions and measures in separate PDF documents making it cumbersome to navigate through the different documents. Please note that the questions were not asked in this order (the interview battery is much more extensive).

Major Depressive Episode

DEPRESSION (12-MONTH)

D_MDE12. Endorsed DSM-IV Major Depressive Episode in the past 12 months. This was determined based on the diagnostic questionnaire.
Endorsed…….1
Not endorsed……..…2

Note: the following questions were used to create the previous item in the data set.

D64. (RB, PG 7-8) For the next questions I need you to think about the period of (several days/two weeks) or more during the past 12 months when your (sadness/or/discouragement/or/lack of interest/or/feeling that life had no meaning) was most severe and frequent. I'm going to read nine series of statements. Please pick the one statement in each series that comes closest to your experience during that worst (several days/two weeks).

D64a. Here's the first series, which deals with problems falling asleep:

One: You never took longer than 30 minutes to fall asleep. Two: You took at least 30 minutes to fall asleep, less than half the time. Three: You took at least 30 minutes to fall asleep, more than half the time. Four: You took more than 60 minutes to fall asleep, more than half the time.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life

has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998
REFUSED 999

D64b. Here's the next series, which deals with waking up at night:

One: You did not wake up at night.

Two: You had a restless, light sleep with few brief awakenings each night.

Three: You woke up at least once a night, but you got back to sleep easily.

Four: You woke up more than once a night and stayed awake for 20 minutes or more, more than half the time.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998
REFUSED 999

D64c. Here's the next series, which deals with waking up too early in the morning:

One: Most of the time, you woke up no more than 30 minutes before you needed to get up.

Two: More than half the time, you woke up more than 30 minutes before you needed to get up.

Three: You almost always woke up at least one hour or so before you needed to, but you went back to sleep eventually.

Four: You woke up at least one hour before you needed to and couldn't get back to sleep.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998

REFUSED 999

D64d. Here's the next series, which deals with the amount of sleep you got each night. Again, pick the one statement that's closest to your experience.

One: You slept no longer than 7-8 hours/night, without napping during the day.

Two: You slept no longer than 10 hours in a 24-hour period including naps.

Three: You slept no longer than 12 hours in a 24-hour period including naps.

Four: You slept longer than 12 hours in a 24-hour period including naps.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998

REFUSED 999

D64e. Here's the next series, which deals with feeling sad:

One: You did not feel sad.

Two: You felt sad less than half the time.

Three: You felt sad more than half the time.

Four: You felt sad nearly all the time.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998

REFUSED 999

D64f. Here's the next series, which deals with your ability to concentrate and make decisions:

One: There was no change in your usual capacity to concentrate or make decisions.

Two: You occasionally felt indecisive or found that your attention wandered.

Three: Most of the time, you struggled to focus your attention or to make decisions.

Four: You couldn't concentrate well enough to read or you couldn't make even minor decisions.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998

REFUSED 999

D64g. Here's the next series, which deals with feeling down on yourself:

One: You saw yourself as equally worthwhile and deserving as other people.

Two: You were more self-blaming than usual.

Three: You largely believed that you caused problems for others. Four: You thought almost constantly about major and minor defects in yourself.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998

REFUSED 999

D64h. Here's the next series, which deals with your interest in daily activities:

One: There was no change from usual in how interested you were in other people or activities.

Two: You noticed that you were less interested in people or activities.

Three: You found you had interest in only one or two of your formerly pursued activities.

Four: You had virtually no interest in formerly pursued activities.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998

REFUSED 999

D64i. Here's the next series, which deals with your energy:

One: There was no change in your usual level of activity.

Two: You got tired more easily than usual.

Three: You had to make a big effort to start or finish your usual daily activities (for example, shopping, homework, cooking, or going to work).

Four: You really couldn't carry out most of your usual daily activities because you just didn't have the energy.

(IF NEC: Which of these four statements was most true of you during your worst (several days/two weeks) of being (sad/or/discouraged/or/uninterested/or/with the feeling that life has no meaning) in the past 12 months?)

_____ NUMBER

DON'T KNOW 998

REFUSED 999

DEMOGRAPHICS

SEX

SEX. (Original question not provided, but this is the corresponding variable in the data set)

MALE…….. 1

FEMALE……. 2

ETHNICITY

DM1.1. Are you of Spanish or Hispanic descent, that is, Mexican, Mexican American, Chicano, Puerto Rican, Cuban or Spanish?

(IF NEC: Which one?)

NOT SPANISH/HISPANIC..... 1
MEXICAN ..... 2 **GO TO DM1.2**
MEXICAN AMERICAN ..... 3 **GO TO DM1.2**
CHICANO ..... 4 **GO TO DM1.2**
PUERTO RICAN ..... 5 **GO TO DM1.2**
CUBAN ..... 6 **GO TO DM1.2**
OTHER SPANISH (SPECIFY).....7 **GO TO DM1.2**
DON'T KNOW 8
REFUSED 9

AGE

DM1. (*DE2) The next few questions are for classification purposes. What are the day, month, and year of your birth? (This was recoded into 4 groups: (1) 18 through 34, (2) 35 through 49, (3) 50 through 64, and (4) 65 and up.)

_____ / _____ / _____

DAY MONTH YEAR

DON'T KNOW 998

REFUSED 999

COUNTRY OF ORIGIN

DM1.6. (*DE4) In what country were you born?

INTERVIEWER: START TYPING THE NAME OF THE COUNTRY.

_____ COUNTRY CODE

UNITED STATES .....1 **GO TO *DM1.7**

OTHER (SPECIFY:).....2 _____

DON'T KNOW .....98 **GO TO *DM1.7**

REFUSED .....99 **GO TO *DM1.7**

EDUCATION

DM1.14. What is the highest grade of school or year of college you completed? (this variable was recoded into four categories: (1) 0-11 years, (2) 12 years, (3) 13 to 15 years, and (4) greater than or equal to 16 years)

IF Nec. PROBE: How many years of school did you complete?
IF "HIGH SCHOOL GRADUATE": CODE '12' YEARS
IF "COLLEGE GRADUATE": CODE '16' YEARS

NONE 0
ONE 1
TWO 2
THREE 3
FOUR 4
FIVE 5
SIX..... 6
SEVEN 7
EIGHT 8
NINE..... 9
TEN 10
ELEVEN..... 11
TWELVE..... 12
THIRTEEN..... 13
FOURTEEN 14
FIFTEEN 15
SIXTEEN..... 16
SEVENTEEN OR MORE 17
DON'T KNOW 98
REFUSED.....99

EMPLOYMENT

EM7.1. What about your current employment situation as of today -- are you (IF ***EM1** DOES NOT EQUAL '997' AND ***EM2** DOES NOT EQUAL '997': currently employed, self-employed), looking for work, disabled, temporarily laid off, retired, a homemaker, a full-time or part-time student, or something else? (this variable was recoded into 3 categories: (1) Employed, (2) Unemployed and (3)Not in labor force.)

INTERVIEWER: DO NOT READ LIST, CIRCLE ALL THAT APPLY, DO NOT PROBE FOR OTHERS

EMPLOYED 1
SELF-EMPLOYED 2
LOOKING FOR WORK; UNEMPLOYED 3
TEMPORARILY LAID OFF..... 4
RETIRED..... 5
HOMEMAKER..... 6
STUDENT..... 7
MATERNITY LEAVE 8
ILLNESS/SICK LEAVE..... 9
DISABLED 10
OTHER (SPECIFY)..... 11

_____

_____

DON'T KNOW 98
REFUSED 99

MARITAL STATUS

MAR3CAT. Marital status 3 categories (this variable was created from original variable, which was not provided in data set).
Married/Cohabitating……1
Divorced/Separated/Widows……...2
Never Married……3

INCOME

FN9. (RB, PG45: Still using the categories on page 45) (What was/ Which letter best represents) your total family household income from Social Security Retirement benefits? (Your best estimate is fine.) This question was recoded into four categories: (1) 0 through

14,999, (2) 15,000 through 34,999, (3) 35,000 through 74, 9999, and (4) 75,000 and up.

_____ LETTER FROM TABLE (HOUSEHOLD SOCIAL SECURITY RETIREMENT BENEFITS)

DON'T KNOW 8
REFUSED 9

NUMBER OF CHILDREN

CN1. The next questions are about children. How many living biological children do you have, not counting stepchildren, adopted children, or foster children?

_____ BIOLOGICAL CHILDREN

NONE 00
DON'T KNOW 98
REFUSED 99

RISK FACTORS

FINANCIAL STRAIN

FN14. In general, would you say (you have/ your family living here has) more money than you need, just enough for your needs, or not enough to meet your needs?

MORE THAN NEED..... 1 **GO TO *MR16, NEXT SECTION**

JUST ENOUGH 2
NOT ENOUGH 3
DON'T KNOW 8
REFUSED 9

PERCEIVED DISCRIMINATION

DS4. How often do people dislike you because you are [**Should be filled from the answers to the following questions depending on whether the R identifies with one or more ethnic or race groups DM1.1 or DM1.3.a and DM1.5 or DM1.5.b**] -- often, sometimes, rarely or never?

OFTEN.....1
SOMETIMES.....2 RARELY
.....3
NEVER 4

DS5. How often do people treat you unfairly because you are **[Should be filled from the answers to the following questions depending on whether the R identifies with one or more ethnic or race groups DM1.1 or DM1.3.a and DM1.5 or DM1.5.b]**-- often, sometimes, rarely or never?

OFTEN.....1
SOMETIMES.....2 RARELY
.....3
NEVER 4

DS6. How often have you seen friends treated unfairly because they are [**Should be filled from the answers to the following questions depending on whether the R identifies with one or more ethnic or race groups DM1.1 or DM1.3.a and DM1.5 or DM1.5.b**]-- often, sometimes, rarely or never?

OFTEN.....1
SOMETIMES.....2 RARELY
.....3
NEVER 4

RELIGION

DA35. When you have problems or difficulties in your family, work, or personal life, how often do you seek comfort through religious or spiritual means, such as praying, meditating, attending a religious or spiritual service, or talking to a religious or spiritual advisor – often, sometimes, rarely, or never?

VERY CLOSE 1
SOMEWHAT CLOSE.....2 NOT
VERY CLOSE .....3 NOT AT ALL
.....4
DON'T KNOW 8
REFUSED 9

FAMILY RELATIONAL WELLBEING

FC1.1 Now I'd to know how strongly you agree or disagree with the following statements about your family.	**STRONGLY AGREE (1)**	**SOMEWHAT AGREE (2)**	**SOMEWHAT DISAGREE (3)**	**STRONGLY DISAGREE (4)**
FC1. Family members respect one another.	1	2	3	4
FC2. We share similar values and beliefs as a family. FC3. Things work well for us as a family.	1	2	3	4
FC4. We really do trust and confide in each	1	2	3	4

other.				
FC5. Family members feel loyal to the family.	1	2	3	4
FC6. We are proud of our family.	1	2	3	4
FC7. We can express our feelings with our family.	1	2	3	4
FC8. Family members like to spend free time with each other.	1	2	3	4
FC9. Family members feel very close to each other.	1	2	3	4
FC10. Family togetherness is very important.	1	2	3	4

APPENDIX B: Screener Form (English)

I would like to ask you a few questions before we start the interview. These questions are to make sure that you that the study is a good fit for you. We ask these questions to all the women who are interested in participating.

1. Are you married or do you live with a significant other?
   ____Yes
   ____**No**

2. Do you have children? [make note of number and ages]
   ____Yes
   ____**No**

3. I am going to read the following scenario and for would like you to tell me if you have experienced this before.

'Silvia has been feeling unusually sad and miserable for the last few days. Even though she is tired all the time, she has trouble sleeping nearly every night. Sometimes she doesn't feel like eating and has lost weight. Silvia can't keep her mind on her work and even day-to-day tasks seem too much for her.'

3(a). What do you think is going on with Silvia?

3(b). Have you ever experienced periods of time with these symptoms?

____Yes [ask 3(c)]
____**No**

3(c). Were you diagnosed by a doctor or other professional?

____**Yes**
____No

Not eligible if:

- They answered NO to both questions 1 and 2 OR
- If they answered NO question 3(b)
- If they answered YES to question 3(c)

APPENDIX C: Screener Form (Spanish)

Me gustaría hacerle una preguntas antes de comenzar con la entrevista. Estas preguntas son solamente para asegurarme que el estudio es apropiado para usted. Nosotras preguntamos estas preguntas a todas las mujeres que están interesadas en participar.

1. Esta usted casada o viven con su pareja?
   ___Si
   ___**No**

2. Tiene hij@s? [Anotar cuanto y que edades]
   ___Si
   ___**No**

3. Le voy a leer sobre la situación de una persona y me gustaría que me dijera si usted a pasado por algo así ante

'Silvia se ha sentido inusualmente triste y miserable en los últimos días. Aunque se siete cansada todo el tiempo, le da trabajo dormirse case cada noche. A veces no tiene ganas de comer y ha perdido peso. Silvia no puede concentrarse en el trabajo y hasta las cosas diarias parecen mucho para ella.'

3(a). ¿Que cree que le pasa a Silvia?

3(b) ¿Le ha pasado a usted esto en alguna ocasión o ha tenido periodos de tiempo con algunos de estos síntomas?

___Si [preguntar 3(c)]

___**No**

3(c) ¿A sido diagnosticada por un doctor o algún otro professional?

___Si

___**No**

No es elegible si:

- Contesta NO a las preguntas 1 y 2 O
- Si contesta NO a la pregunta 3(b)
- Si contesta Si a la pregunta 3(c)

APPENDIX D: Informed Consent (English)

Thank you for taking the time to talk to me today. Before we begin I need to obtain your consent to be part of the study. [HANDS INTERVIEWEE THE CONSENT FORM]. This form explains this research project and your rights as a participant. You will get a copy of this form to keep.

- The purpose of this research is to learn more about Latinas experiences with depression and the circumstances that contributed to periods of depression. We would also like to know how you coped and dealt with depression. This research is being conducted by researchers at Michigan State University

How to Participate and What Will Happen
By signing this consent form, you are giving permission to be involved in a face-to-face interview. The interview will center on your depression experiences and how you dealt and coped with it.

If you decide to participate, your participation will include:
1) A complete explanation of the study and this consent form.
2) An interview that should take about one hour.

I will explain the project as we go over the informed consent form together, and you will then be asked to participate in the study. Upon completion of the interview, you will be given a $20 gift card as a token of appreciation for you time.

Risks /discomforts and Benefits:
There is the potential for minimal risk involved with participating in this study. Some psychological discomfort could be experienced from thinking about and revealing personal information about your depression experiences. You are able to take a break at any point during the interview; you are also able to refuse to answer any questions that make you uncomfortable. If you are unable to complete the interviews due to psychological discomfort, you will still receive the appropriate compensation for your time. After the interview, should you feel overwhelmed or stressed please inform the researcher for referrals to mental health agencies.

There are also some potential benefits. In addition to the small payment for your time, you may experience indirect benefits from your participation by sharing your experiences with others. Furthermore, your participation in this study may contribute to the larger community having a better understanding of the experience of Latinas' experiences of depression.

Recording:
All interviews will be audio taped. You will not be permitted to participate in the study without being audio taped. Only the researchers on the team will have access to the recordings. The recordings will be transcribed verbatim and deleted once the typed transcripts are checked for accuracy. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products related to the study. Your name or other identifying information

will NOT be used in presentations or in any written reports of this study. Immediately following the interview, you will be given the opportunity to have the recording deleted if you wish to withdraw your consent to participate in this study.

- By consenting to the researcher's recording, you are agreeing to have your interview recorded, to having the recording transcribed and to the use of the written transcript in presentations and written products. Please check the following box if you voluntarily agree to have the interview recorded.
    - ❑ I voluntarily agree to having my interview audio recorded and transcribed and to the use of the written transcript in presentations and written products as explained to me.

Confidentiality:
Your confidentiality will be protected to the maximum extent allowable by law. However, in the course of this interview, if you reveal information that indicates that you are a danger to yourself or others, or information regarding abuse of a child, elder, or vulnerable person, we must break confidentiality and contact the appropriate authorities.

The researchers would like to audiotape each interview in order to ensure accuracy. When audio tapes are transcribed verbatim any identifying information will be deleted (i.e., names of people or places) to protect your identity. Typed transcripts of your interview will be kept as password-protected files, and access to the information will be limited to the researcher, the research team members and the Michigan State University's Human Research Protection Program. Michigan State University may review your research records. All research data for this study will be kept in password-protected files at the primary researcher's Michigan State University address for a minimum of 3 years after the conclusion of the project. Transcripts of your interview may be reproduced in whole or in part for use in presentations or written products related to the study, but any identifying information will be removed and will not be used in those presentations or written reports resulting from this study. Immediately following the interview, you will be given the opportunity to have the recording deleted if you wish to withdraw your consent to participate in this study.

Other than this form, all questionnaires and data will be identified with a code number. A list linking your name to the code will be kept in a locked file for the duration of the study. Once all the data are collected and analyzed, the list linking the names to the code numbers will be destroyed.

Voluntary participation:
Your participation in this study is strictly voluntary. You may decline to answer any question in the study. You may decline participation at any point during the study by simply telling the interviewer you no longer wish to participate.

Rights and complaints:
If you have any concerns or questions about this research study, such as scientific issues, how to do any part of it, or if you believe, you have been harmed because of the research, please contact the researcher:

Marsha Carolan, PhD
7 Human Ecology Building
East Lansing, MI 48824
(517) 432-9115, or (618) 531-1871
carolan@msu.edu

If you have questions or concerns about your role and rights as a research participant, you would like to obtain information or offer input, or you would like to register a complaint about this study, you may contact, anonymously if you wish, the Michigan State University's Human Research Protection Program at 517-355-2180, Fax 517-432-4503, or e-mail irb@msu.edu or regular mail at 207 Olds Hall, MSU, East Lansing, MI 48824.

- YOU HAVE READ THE CONSENT FORM.
- YOUR QUESTIONS HAVE BEEN ANSWERED.
- YOUR SIGNATURE ON THIS FORM MEANS THAT YOU CONSENT TO PARTICIPATE IN THIS STUDY.
- YOU ALSO CERTIFY THAT YOU ARE 18 YEARS OF AGE OR OLDER.

❑ I voluntarily agree to participate in a one-on-one interview.

_____
Initials

_____	_____
Signature of Participant	Signature of Researcher
_____	_____
Typed/Printed Name of Participant	Typed/Printed Name of Researcher
_____	_____
Date	Date

APPENDIX E: Informed Consent (Spanish)

Gracias por tomarse el tiempo para hablar conmigo. Antes de empezar necesito obtener su consentimiento para participar en este estudio. [ENTREGAR HOJA DE CONSENTIMIENTO INFORMADO A LA PARTICIPANTE]. Esta forma explica este proyecto de investigación y sus derechos como participante. Usted se quedara con una copia de esta forma.

- El propósito de este estudio es de aprender mas acerca de las experiencias de depresión en las mujeres Latinas y de las circunstancias que contribuyen a los periodos de presión. También nos gustaría saber como usted afronta con la depresión. Este estudio es por parte de investigadores/as en la Universidad Estatal de Michigan.

Como Participar y en que consiste la participación
Al firmar esta forma de consentimiento, da permiso de participar en un entrevista cara a cara. La entrevista se enfocara en sus experiencias de depresión y su afrontamiento con tal.

Su participación incluirá:

1) Una explicación complete del estudio y de esta forma de consentimiento.
2) Una entrevista de una hora.

Explicare el proyecto mientras leemos esta forma de consentimiento informado, y le preguntara si desea participar en el estudio. Una vez que se termine la entrevista, se le dará la tarjeta de regalo de $20 dólares.

Riesgos/incomodidades y Beneficios:
Hay un menor riesgo posible en participar en este proyecto. Algunas incomodidades psicológicas pueden resultar por recordar y compartir información personal relacionada con la sus experiencias de depresión. Usted puede tomarse un descanso en cualquier momento durante la entrevista; usted también puede negarse a contestar cualquier pregunta que la haga sentir incomoda. Si usted no puede terminar la entrevista debido a incomodidad psicológica, usted aun recibirá la compensación apropiada por su tiempo. Después de la entrevista, si usted se siente estresada por favor contacte a la investigadora para que le de información de agencias de salud mental.

También hay posibilidad de algunos beneficios. Además de la cantidad pequeña de pago por su tiempo, usted puede sentir beneficios indirectos por su participación al haber compartido sus experiencias con otra persona. Además, su participación en este estudio puede contribuir a la comunidad proveyendo un mejor entendimiento de las experiencias de las mujeres.

Grabación:
Todas las entrevistas serán grabadas. No se le permitirá participar en el estudio sin grabar la entrevista. Solamente las investigadoras del estudio tendrán acceso a las grabaciones. Las grabaciones serán transcritas y serán destruidas una vez que la entrevista sea transcrita y revisada por precisión. El transcrito de la entrevista puede ser reproducido completamente o partes para

ser usado en presentaciones o escritos relacionados con el estudio. Su nombre o información de identidad NO serán usados en presentaciones o en ningún reporte escrito de este estudio. Inmediatamente después de la entrevista, se le dará la oportunidad de borrar la grabación si desea ya no participar en el estudio. Al aceptar que la entrevistadora use la grabadora de voz, usted esta consistiendo que su entrevista sea grabada, a que se transcriba la grabación y al uso de el documento transcrito en presentaciones o en cosas escritas.

Confidencialidad:
Su confidencialidad será protegida al máximo grado permitido por la ley. Sin embargo, en el curso de la entrevista, si usted comparte información que indique que usted es un peligro para si misma u otros, o información acerca de abuso de niña/o, persona mayor, o vulnerable, nosotros debemos romper confidencialidad y reportar a las autoridades correspondientes.

Al equipo de investigación le gustaría grabar cada entrevista para asegurar precisión. Cuando las grabaciones sean transcritas cualquier información que la pueda identificar será borrada (por ejemplo, nombres de personas o lugares) para proteger su identidad. Los transcritos de su entrevista serán mantenidos como documentos protegidos con contraseña, y acceso a la información será limitado a la investigadora, a los miembros del equipo de investigación y al programa de protección de investigación con humanos en la Universidad Estatal de Michigan (un grupo que se asegura que los derechos de los participantes estén protegidos). La Universidad Estatal de Michigan podría revisar sus documentos de la investigación. Todos los datos de información de este estudio estarán protegidos en documentos con contraseña en la oficina principal de la investigadora en la Universidad Estatal de Michigan por los menos por 3 años después de se termine el estudio. Los transcritos de su entrevista pueden ser reproducido completamente o partes para ser usado en presentaciones o escritos relacionados con el estudio, pero cualquier información que la pueda identificar será borrada y no será usada en las presentaciones o en los reportes escrito de este estudio. Inmediatamente después de la entrevista, se le dará la oportunidad de borrar la grabación si desea ya no participar en el estudio.

Todos los demás documentos y datos de información, excepto por este, serán identificados con un numero de código. Una lista relacionando su nombre con el código será mantenido en un expediente con llave por la duración del estudio. Una vez que todos los datos sean recolectados y analizados, la lista con los nombres será destruida.

Participación Voluntaria:
Su participación en este estudio es completamente voluntaria. Usted puede no contestar cualquier pregunta en el estudio. Usted puede negarse a participar en cualquier momento durante el estudio con solo decirle a la entrevistadora que usted ya no desea participar.

Derechos y quejas:
Si usted tiene cualquier preocupación o preguntas sobre el estudio de investigación, tal como cuestiones acientíficas, como participar en cualquier parte del estudio, o si usted cree que a sido lastimada por el estudio, por favor comuníquese con la investigadora:

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7 Human Ecology Building
East Lansing, MI 48824
(517) 432-9115, o al (618) 531-1871
carolan@msu.edu

Si usted tiene preguntas o preocupaciones a cerca de su papel en el estudio y sus derechos como participante, si le gustaría obtener información u ofrecer sugerencias, o si le gustaría registrar una queja acerca de este estudio, usted puede comunicarse, anónimamente si gusta, con el programa de protección de investigación con humanos en la Universidad Estatal de Michigan al numero 517-355-2180, Fax 517-432-4503, o correo electrónico irb@msu.edu o correspondencia 207 Olds Hall, MSU, East Lansing, MI 48824.

- HE LEÍDO ESTA FORMA.
- MIS PREGUNTAS HA SIDO CONTESTADAS.
- SU FIRMA EN ESTA FORMA INDICA QUE USTED DA CONSENTIMIENTO PARA PARTICIPAR EN ESTE ESTUDIO.
- USTED CONFIRMA QUE USTED TIENE POR LO MENOS 18 ANOS DE EDAD.

- **Yo voluntariamente acedo a participar en esta entrevista.**

- **Yo voluntariamente doy consentimiento a que se grabe mi entrevista y a que sea transcriba y al uso del transcrito en presentaciones y en escritos que me han explicado.**

_____
Iniciales

_____	_____
Firma de la Participante	Firma de la Investigadora
_____	_____
Nombre escrito de la Participante	Nombre escrito de la Investigadora
_____	_____
Fecha	Fecha

APPENDIX F: Interview Guide (English)

A lot of people and in particular women experience depression. We also know that a lot of women find ways to deal with it and recover. We are very interested in learning about the reasons why Latina women go through depression and how they manage to overcome it and recover.

First, I would like to ask you a few questions to get to know you better.

1. How old are you?

2. What is your marital status?

3. Do you have children?

4. Are you currently employed?

5. What is the highest grade or level of school that you have completed?

6. Where were you born?

    a. If born outside of the U.S., ask: how old where you when you moved to the U.S.?

Now, I am going to ask you some questions related to your experiences being a woman and being Latina.

7. Have you ever been treated different, in a negative way, because you are a woman?
    a. Probe: have you noticed that you have had fewer opportunities because you are a woman?
    b. Probe: Sometimes these things happen and they are less obvious than when something is said, but they can be felt by looks and body language.

8. Do you feel that you have been treated different, in a negative way, or that you have had fewer opportunities because you are a Latina?
    a. Probe: Have you had any experiences where people were rude to you, said an insult or mocking comment related to your culture or ethnicity?

Next, I would like to ask you some questions related to depression and ways you dealt with it.

9. How many times would you say you have experienced depression in your life?
    a. If more than once, ask about how long ago was the last incident?

10. When you were going through these (depression) periods, can you describe how you felt?
    a. Probes: emotionally, mentally, physically, energy levels, relationships, everyday life, work, etc.

11. Now, I would like you to think of the things that were going on in your life that may have contributed to (each of) the depression period(s)?
    a. Probe: Was any thing happening at work, in your community or with your family?

12. How would you describe coping with your depression experiences?
    a. Probe: what kind of things would you say to yourself?
    b. Probe: What kind of things would you do to help you get better?

13. Did anyone help you when you experienced depression?
    a. Probe for emotional expression, communication and problem solving, and functioning

    b. 13a. [Only ask if they don't mention this in their answer to Q.13] Did any family relatives helped?

c. 13b. [Only ask if they don't mention this in their answer to Q.13] How about anyone in the community?

14. Were there any advice or sayings that helped you? (make a note of the source)

14a. [Only ask if they don't mention in previous answer] In the Latino culture, which we know is diverse, there are different cultural values like valuing the family, having good relationships with others, and other similar things, do you think that any cultural value helped you deal with depression or helped you feel better?

a. Probe: other cultural values include sacrificing for the children and the family (marianismo), loyalty, and respect (the last two apply to work environment)

15. That is all the questions I had for you today. Before we end the interview, is there anything else about Latinas' experiences of depression that is important for me to know about or anything else that would like to tell me?

APPENDIX G: Interview Guide (Spanish)

Muchas personas y en particular las mujeres pasan por periodos de depresión. También sabemos que muchas mujeres encuentran maneras de afrontar la depresión y de recuperarse. Nosotros estamos muy interesados en aprender acerca de las razones porque las mujeres Latinas pasan por periodos de depresión y de como se recuperan.

Primero me gustaría preguntarle algunas preguntas para conocerla mayor.

1. Cuantos anos tiene?

2. Cual es su estado civil?

3. Tiene hij@s?

4. Esta empleada?

5. Cual es el grado escolar mas alto que complete?

6. En donde nació?
    a. Si no nació en los Estados Unidos, preguntar cuantos anos tenia cuando se movió a los USS.

Ahora, le voy a preguntar algunas preguntas relacionadas con sus experiencias por ser mujer y por ser Latina.

7. La han tratado diferente, de manera negativa, porque ser mujer?
    a. Probe: a notado que tenia menos oportunidades por ser mujer?
    b. Probe: a veces estas cosas pasan y no san tan obvias como cuando algo dicho, pero se siente por medio de miradas o lenguaje del cuerpo.
8. Siente que la han tratado diferente, de alguna manera negativa, o que a tenido menos oportunidades por ser Latina?
    a. Probe: Le a pasado que otras personas son groseras con usted, o le han dicho algún insulto o comentario en burla relacionada con su cultura o grupo étnica?

En la esta siguiente parte me gustaría preguntarle acerca de sus experiencias de depresión.

9. Cuantas veces diría usted que a pasado por periodos de depresión en su vida?
    a. Si mas de una vez, preguntar el lapso de tiempo desde el ultimo período.

10. Cuando estaba pasando por estos periodos de depresión, podría describir como se sentía?
    a. Probes: emocional, mental, física, niveles de energía, relaciones, trabajo, cosas cotidianas, etc.

11. Ahora, quisiera que pensara en las cosas o circunstancias que estaban pasando en su vida que pudieran haber contribuido a los periodos de depresión?
    a. Probe: Pasaba algo en el trabajo, en su comunidad o con su familia?

12. Como describiría su afrontamiento con la depresión/
    a. Probe: ¿qué tipo de cosas se decía a usted misma?
    b. Probe: ¿qué tipo de cosas hacia para sentirse mayor?

13. Hubo alguna persona o personas que le ayudaron en su período de depresión?
    a. Probe for emotional expression, communication and problem solving, and functioning.
    b. [Solo preguntar si no lo menciono en la respuesta de la P13] Le ayudaron miembros de la familia?
    c. [Solo preguntar si no lo menciono en la respuesta de la P13] Le ayudo alguien mas en la comunidad?

14. Hubo consejos o dichos que le ayudaron?

    14.a. [Solo preguntar si no lo menciono en la respuesta anterior] En la cultura Latina, que como sabemos es diversa, hay diferentes valores culturales como valorar la familia, el tener buenas relaciones sociales con otros, y otras cocas

similares. Piensa usted que alguna de estos valores culturales le ayudo a afrontar la depresión o le ayudo a sentirse mejor?

a. Probe: other cultural values include sacrificing for the children and the family (marianismo), loyalty, and respect (the last two apply to work environment)

15. Estas son todas las preguntas que tengo para usted. Antes de terminar la entrevista, hay alguna otra cosa acerca de las experiencias de depresión en las mujeres Latinas que sea importante para mi saber, o alguna otra cosa que le gustaría compartir?

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