“*¿ES DIFÍCIL SER MUJER?*” DEPRESSION, GENDER ROLE BELIEFS, AND ACCULTURATION: TESTING THE USE OF A CULTURALLY GROUNDED INTERVENTION TO REDUCE DEPRESSIVE SYMPTOMS AMONG SPANISH-SPEAKING LATINAS

A Dissertation

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ABSTRACT

Research identifies Latinas as a high-risk group for depression. Although many experience symptoms of depression, many are under-diagnosed and/or underutilize mental health services. To address the service gap, this study evaluated the effectiveness of a Promotora led, modified version of *"¿Es Difícil Ser Mujer? Una Guía Sobre Depresión*" (Is It Difficult Being A Woman? A Guide to Depression) (EDSM), a culturally-grounded depression curriculum aimed at reducing depressive symptoms among Spanish-speaking Latinas. The secondary goal of the study was to examine whether the EDSM intervention influenced Latina gender role beliefs.

A sample of twenty-five Spanish-speaking Latinas, primarily of Mexican/Mexican-American descent (92%) with a mean age of 40.64 (*SD* = 10.38) reported higher PHQ-9 total scores at pre-treatment than non-treatment completers. Key findings indicate that as a group, the intervention was related to a decrease in depression symptoms among participants. There was limited support at the individual level. Findings indicate that gender role beliefs were influenced, specifically, Virtuous and Chaste and Spiritual Pillars.

DEDICATION

To my father, mother, and sister, who have been with me through this journey,

"*en las buenas y las malas*."

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"It always seems impossible until it's done." ~ Nelson Mandela

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NOMENCLATURE

AE	Actively Engaged
ALT	Adult Learning Theory
CBPR	Community-Based Participatory Research
CHW	Community Health Worker
CP	Community Participant
EDSM	"¿Es Difícil Ser Mujer?" Una Guía Sobre Depresión" (Is It Difficult Being A Woman? A Guide to Depression)
NE	Not Engaged
MBS	Multiple-Baseline Across Subjects Design
PE	Partially Engaged
PI	Principal Investigator
Promotora	Community Health Worker, Lay Worker
SCR	Single Case Research

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CHAPTER I

INTRODUCTION AND LITERATURE REVIEW

Depression is a critical public health concern that may even be considered the most disabling condition in the United States (Cassano & Fava, 2002; Sartorius, 2003; Ussher, 2010). In particular, mental health practitioners and researchers have identified Latinos as a high-risk group for depression (National Alliance for Hispanic Health, 2001). In Latina women, the prevalence of depression is at 46% compared to Latino men at 19.6%, according to census data (Vega & Amaro, 1994). Although there are empirically established interventions to treat depression, such as Cognitive Behavioral Therapy (Beck, 1995; Shattell, Quinlan-Colwell, Villalba, Ivers, & Mails, 2010), these treatments are typically underutilized by Latinos. Compared to Blacks and Whites who receive mental health treatment or counseling at rates of 7.7% and 16% respectively, Latinos receive the least at 7.3% (Substance Abuse and Mental Health Services Administration [SAMHSA], 2012). This underutilization of mental health services contributes further to under-diagnosis of depression symptoms experienced by Latinos (Berdahl & Torres Stone, 2009; Cavazos-Rehg, Zayas, & Spitznagel, 2007; Department of Health and Human Services, 2001; SAMHSA, 2012; Young, Klap, Sherbourne, & Wells, 2001).

In 2001, the Surgeon General Report called to address the service gap by advocating for research focusing on the development and testing of evidence-based culturally appropriate mental health interventions for Spanish-speaking Latinos. In line

with this mission, the present study aims to expand research on a culturally grounded intervention for Latinas given the high prevalence of depression in this population. Lara, Acevedo, Luna, Weckmann, Villarreal, and Pego (1997) developed an innovative intervention targeting depression in Latina women. This intervention is called *"¿Es Difícil Ser Mujer? Una Guía Sobre Depresión*" (Is It Difficult Being A Woman? A Guide to Depression), or EDSM. This study evaluated the effectiveness of a modified version of EDSM at reducing depressive symptoms among Spanish-speaking Latinas.

Depression and Latinas

The impact of mental illness on overall health and production in the U.S. and globally is profoundly unaddressed (*Healthy People* 2020). According to a report on the Global Burden of Disease (López, 2002), mental disorders were found to be one of the most disabling illnesses worldwide. Depression is characterized by symptoms such as depressed mood most of the day or nearly every day, markedly diminished interest or pleasure in activities, insomnia/hypersomnia, feelings of worthlessness, and recurrent thoughts of death (DSM 5; American Psychiatric Association, 2013). Mental health disorders, such as depression, represent an immense public health burden given the debilitating effects it can have on individuals (*Healthy People*, 2020), such as impacting the workforce by missing work (Dewa & McDaid, 2011), job strain due to an increase in psychological demands (Smith & Bielecky, 2012), and increased vulnerability to suicide (National Council of La Raza [NCLR], 2005; SAMHSA, 2012). Depression is one of the most prevalent and treatable mental disorders. However, depression is not something that people can just pull themselves out of or "just get over" (Delgado, 2010; Kroenke &

Spitzer, 2002). As with any other medical condition (e.g., diabetes), depression requires treatment.

Copious research has identified critical factors that may contribute to depression among Latinas. For example, González, Haan, and Hinton (2000) using a population-based sample of 1,663 participants (85% were of Mexican descent; 58.2% were female; 50% were immigrant) found that depressive symptoms were higher among women than men. The higher statistic among women may be attributed to men underreporting symptoms. In this study, acculturation was linked to depression. Immigrants and less-acculturated (vs. highly acculturated) individuals were significantly at higher risk for depressive symptoms. However, other studies have found that higher acculturation increases risk for depression. Finch, Kolody, and Vega (2000) using data from the Mexican American Prevalence and Services Survey (MAPSS), a probabilistic samples of 3,012 Mexican origin participants (46% women; n = 1,405) from Fresno, California found that more highly acculturated immigrant participants (n = 1,888) were more likely to experience discrimination, which was then linked to higher symptoms of depression. Migration-related factors may also shape mental health. Among a convenience sample of 143 Latino immigrants, primarily from Mexico (88%) and 56% female, Cavazos-Rehg et al., (2007) found that negative emotional distress was associated with concerns over deportation. Within the context of Latina women, studies have documented associations between depressions and low-income, immigration status, the acculturation process, discrimination, and gender role conflict (Cavazos-Rehg et al., 2007; Finch, Kolody, &

Vega, 2000; González, Haan, & Hinton, 2001; Kiang, Grzywacz, Marín, Arcury, & Quandt 2010; Miranda et al., 2006).

Low-Income and Depression

Financial stability is a major stressor that is often associated with depression among Latinas; this is in part related to Latinas low-income status and/or immigration status. Latinos, including women, commonly work multiple jobs to make ends meet (Martínez Pincay & Guarnaccia, 2007). For recent immigrants, many Latinas may find jobs that are irregular, low paying, oppressive, and have to perform physically unsafe duties (Cavazos-Rehg, Zayas, Spitznagel, 2007). Results from Cavazos-Rehg et al. (2007) indicated that Latina immigrants with questionable legal status may be forced to accept low-paying jobs, may experience challenges in finding a desired job, and may endure difficulties in getting promotions or increased salaries. Latinos are also more likely to work in the service sector (e.g., food service, janitorial, garment industry) compared to non-Latino Whites, 22.1% and 11.6% respectively (U.S. Census Bureau, 2003). Given that a substantial number of Latinos work in the service sector, their wages are minimal in comparison to Whites. According the U.S. Census Bureau (2003), among full-time year round workers, only 26.3% of Latinos earned a minimum of $35,000 annually—compared to 53.8% of their non-Hispanic, White counterparts. Latinos are also more likely to be unemployed (8.1%) compared to Whites (5.1%), and live in poverty (21.4%) compared to Whites (7.8%).

Studies have shown an association between low-income status and poor mental health outcomes, including depression (Cavazos-Rehg et al., 2007; Miranda, Green,

Krupnick, et al., 2006; NCLR, 2005; SAMHSA, 2012;). Among recent Mexican immigrants, financial pressures and meeting economic expectations has been associated with greater depression (Kiang, Grzywacz, Marín, Arcury, & Quandt, 2010; Lazear, Pires, Isaacs, Chaulk, & Huang, 2008). Lazear, Pires, Isaacs, Chaulk, and Huang (2008), conducted a focus group, which found that low-income individuals reported financial pressures stemming from issues with finding employment. This impacted their mental health. A recent study of 121 low-income women (56.7% Latinas) from five counties in California, which examined the risk of depression, found that half of the women reported depressive symptoms (Joy & Hudes, 2010). Those who were Spanish-speaking reported higher symptoms of depression than English-speaking speaking participants. Lastly, in a study of low-income, pregnant Dominican and Puerto Rican women, Zayas, Jankowski and McKee (2003) found that 43% of their sample met criteria for mild to moderate levels of depression; 10% reported symptoms of depression in the severe range. This body of evidence suggests a higher prevalence of depression among low-income Latinas. Importantly, low-income immigrant and U.S. born Latinas continue to underutilize mental health services (Nadeem, Lange, Edge, Fongwa, Belin, et al., 2007).

Acculturation, Immigration, and Depression

Acculturation is a complex psychosocial phenomenon that is comprised of many aspects of human functioning. The theory of acculturation first originated by Redfield, Linton, and Herskovits (1936). They defined acculturation as a phenomena that results when individuals of different cultures come into contact with each other and changes occur in the cultural patterns of both groups through their interaction. Acculturation

theory has been examined throughout the years. Most noteworthy is Berry’s (1980) study, which described six dimensions of psychological functioning related to acculturation, including: language, cognitive styles, personality, identity, attitudes, and acculturative stress. Berry posited that as an individual acculturates to the dominant culture, changes occur in each of these domains.

The most persuasive and relevant definition of acculturation is that of Cuellar, Arnold, and Maldonado (1995), which defined acculturation in terms of changes at three different levels of functioning: behavioral, affective, and cognitive. Behavioral acculturation consists of verbal behavior or language, customs, foods, and cultural expressions, such as the music one listens and dances to. Affective acculturation consists of emotions that have cultural connections. For example, the way a person feels about important aspects of identity, the symbols one loves or hates, and the meaning one attaches to itself, is culturally based. Cognitive acculturation is comprised of beliefs about male/female roles, ideas about illness, attitudes towards illness, and fundamental values.

While some research suggests that acculturation is a stressful process that is often associated with depression (Kposowa, Tsunokai, & Buttler, 2001; Ornelas & Perreira, 2011; Torres & Rollock, 2007) other studies have produced inconsistent findings. This may be a reflection of methodological differences of the operationalization of the construct (Torres & Rollock, 2007). A review of the literature notes at least three different relationships between acculturation and depression. The first relationship indicates that higher acculturation is related to less depression. In one study (Torres &

Rollock, 2007), which recruited a convenience sample of 96 Latinos (89% Mexican, n = 85), the majority immigrants (60%), intercultural competence moderated the relationship between acculturation and depression. In this study, acculturation was measured via the Cultural Life Style Inventory (CLSI) (alpha = 0.96). Torres and Rollock (2007) define intercultural competence as an individual's proficiency regarding culturally relevant areas and group-specific skills that facilitate cultural interactions. In other words, those who acculturate should experience less stress and in their study, fewer depressive symptoms were found.

The second relationship relates to higher acculturation with higher depressive symptomatology. A report by the National Council of La Raza (NCLR) (2005) noted that mental health concerns such as depression, appear to increase among Latino immigrants as they acculturate. For instance, a study using a representative sample of 8,098 participants from the National Comorbidity Survey (NCS) found that an increase in the prevalence of psychiatric and substance use disorders among Latinos may be attributed to increased acculturation (Ortega, Rosenheck, Alegría, & Desai, 2000). In this study Latinos were primarily Mexican, Puerto Rican, 'other Latinos' (i.e., Cuba, Central American, etc.) and mostly foreign-born (60%). Acculturation was operationalized through 4 dichotomous proxy measures, including: (1) nativity (US born vs. immigrant), (2) parental nativity (at least one US born parent vs. both foreign born); (3) language as a child (English vs. not English), and (4) current language at home (English vs. not English).

The third relationship is that lower acculturation is related to higher symptoms of depression. A study among older (age 65+) Mexican Americans (50% foreign-born) using the Acculturation Ratings Scale for Mexican Americans-II (ARSMA-II) to measure acculturation found that depression was higher among immigrants, bicultural participants, and less-acculturated participants when compared to highly acculturated or U.S. born individuals (González, Haan, & Hinton, 2001). The least acculturated participants were at a significantly higher risk for depression than highly acculturated Mexican Americans.

Family Separation, Immigration, and Depression

Related to acculturation processes, is family separation due to U.S. immigration, which has also been linked to depression. When immigrants move to a new country, they commonly leave familiar places and people behind, and often times find themselves isolated in their new environment. Such circumstances contribute to the mental health of immigrants. Martínez, Pincay and Guarnaccia (2007) examined Latino's conceptions of depression, their attitudes towards mental health treatment and their expectations of mental health care. Twelve focus groups were conducted with a diverse group of Latinos in rural and urban settings of New Jersey and New York City. Puerto Ricans, Dominicans, Mexicans, and Cubans aged 20 to over 65 years, who had been in the US from less than 1 year to 28 years participated in the study (n = 94). The focus groups consisted primarily of females (72%; range = 68 - 94%) from low-income backgrounds. Researchers found that participants viewed isolation as the cause for depression and feelings of loneliness as a result of the depression. In another study, separation from

family stress was associated with higher levels of depression among Mexican immigrant women (n = 150) living in the US fewer than five years (Hiott, Grzywacz, Arcury, & Quandt, 2006). Participants in the study experienced feelings of guilt at having to leave family and friends in their home country. Stressors with being an immigrant in the U.S. may adversely impact the mental health of Latina women.

Gender Role Conflict and Depression

Several studies on Latino depression have noted that Latinas report more depressive symptoms than Latino men (e.g., Vega & Amaro, 1994). Additionally, a study that assessed the association between acculturation, immigration, and prevalence of depression among older Mexican Americans (50% foreign-born) found that women were at greater risk for depression than men (González, Haan, & Hinton, 2001). Though studies highlight the increased risk of depression in Latinas, they provide little information as to why Latinas experience depression at higher rates than Latinos. Scholars suggest that the social context of women's lives may contribute to higher rates of depression among women than men (Ussher, 2010). Furthermore, the conflict between a Latina's gender role beliefs and the expected adherence to traditional gender roles has been associated with depression (Dominguez-Barros, 2008; Heilemann, Coffey-Love, & Frutos, 2004). Gender role conflict is defined as a psychological state where socialized gender roles have negative consequences on the person or others and it may occur when rigid, sexist, or restrictive gender roles result in personal restriction, devaluation, or violation of others or self (O'Neil, 2008). For Mexican born women,

gender role socialization may account, in part, for gender differences in depression (Lara, 2008).

Gender Roles Socialization

Gender roles are learned at an early age through the process of enculturation. Enculturation is broadly defined as the retention or acquisition of one's culture of origin (Yoon, Lee, & Goh, 2008); in other words, how one is socialized in their ethnic group's cultural values, beliefs, norms and customs. Latina women have a prescribed set of traditional gender role expectations or "code of behavior" in which they are socialized (Confresi, 2002). For example, some Mexican women are often told, "*calladita te vez mas bonita*," literally meaning "you look prettier when you are quiet/silent." The saying implies that in order to avoid conflict and live in harmony ("*vivir en paz*") with their husband and family members, one should listen, but not voice their opinion. Speaking may contradict their husband, father and/or mother and escalate the situation. This is one example of how Latinas learn to self-silence.

The literature suggests that *marianismo* is a cultural script that stipulates a Latina's gender role. Through *marianismo*, women are enculturated (socialized) at an early age to be self-sacrificing, docile, dependent on family, ignorant about sex, eager to please men at all costs, as well as enduring infidelity for the sake of the family and children to maintain family honor (Gil & Vasquez, 1996; Moreno, 2007; Santiago-Rivera et al., 2002).

Recently, Castillo, Perez, Castillo, and Gosheh (2010) examined the construct of *marianismo.* The authors found that marianismo is comprised of five components that

describe the characteristics Mexican American female participants believed they should possess. The first component, *Family Pillar*, describes the belief that a Mexican-American woman is the main source of strength for her family. Further, she is responsible for keeping the family happy and unified. Related, the cultural value of *familismo* is defined as an individual's attachment and strong identification with nuclear and extended families (Castillo & Cano, 2007). Strong feelings of loyalty, reciprocity, and solidarity among family members frames *familismo* and is characterized by a reliance on relatives for help and support and obligations to provide material and emotional support to the family. Due to Latinas' collectivistic worldview, cooperation and self-sacrifice is deemed natural. Further, Latinas may view themselves as bound to their families and their individual behaviors may be perceived as reflective of the family (Castillo & Cano, 2007). Consequently, Latinas are expected to fulfill the cultural value of *familismo.* In terms of mental health outcomes, *familismo* can be a source of resiliency (Olmedo, 2003; Villenas, 2001), but it can also be harmful to mental health (Zayas, Lester, Cabassa, & Fortuna, 2005).

The second component, *Virtuous and Chaste*, reflects the belief that Mexican American women should be morally pure in thought and sexuality. Due to the cultural value of familismo and individuals behaviors as reflective of the family, Latinas are expected to remain virgins until marriage and not express their sexual needs to their partner. Latina sexuality is seen as a marital/partner duty to fulfill the sexual needs of her husband/partner and not necessarily satisfy her own sexual needs and desires.

The third component, *Subordinate to Others*, describes how Mexican American women must be obedient and respect the hierarchical power structure (Castillo et al., 2010). Being subordinate to others adheres to the cultural value of *respeto* (respect). *Respeto* is a cultural value that involves sensitivity and respect of an individual's position within a hierarchical structure, which includes age, gender, and authority status (Castillo & Cano, 2007). Latinas are expected to respect men and must obey them ("*deben obedecer*"), whether they are their fathers or their husbands ("*sean sus padres o esposos*"). Respecting and obeying may include not "talking back," letting the men make family decisions, and not questioning mens' decision-making. Although *respeto* is a positive cultural value (e.g., respecting elders by addressing them as *Don* or *Doña*), the negative aspect involves inhibiting a person from challenging those who abuse their authority (e.g., domestic violence) (Castillo & Cano, 2007). Thus women learn to self-silence.

The cultural script of *respeto* (respect) may prohibit women from challenging elders or male figures such as her mother, grandmother, father and/or husband (Moreno, 2007). From a very young age, women may be told, "*hazle caso a tu papá/abuela* (don't contradict your father/grandmother)." In these cases, a Latina who adheres strongly to *respeto,* coupled with the belief that "*calladita te vez mas bonita*" (you look prettier when you are quiet/when you don't speak), may be more likley.to self-silence and not express needs or voice concerns because they have learned it as culturally inappropriate or taboo to do so. Conversely, if she believes in challenging the norm, family members might view her negatively and indirectly convey the message to be respectful and adhere

to the cultural script. For example, a father might tell his daughter, "*ahora los patos le tiran a las escopetas* (now the ducks are telling the shotguns what to do)."

Simpatia is a cultural value that consists of behaviors that promote smooth and pleasant social relationships. If a Latina adheres to the cultural norm of *simpatia*, she may seek to avoid conflict and self-silence, potentially creating cognitive dissonance between what she wants and what she should do. Castillo et al. (2010) describe the pressure and belief that Latinas should conform to traditional gender role norms. When this does not occur, this is deemed an internalized conflict. For example, a Latina may be expected to learn to cook and clean to become a housewife when she may be interested in pursuing a college education and build a career for herself.

The fourth component, *Self-Silencing to Maintain Harmony*, illustrated the belief that Mexican-American women should keep their needs and thoughts to themselves in efforts to maintain harmony in relationships. Self-silencing was first conceptualized by Jack (1991) through her work with women and depression. Jack proposes that women may adopt a self-silencing schema based on social expectations that dictate that they must silence certain thoughts, feelings, and beliefs in order to create and maintain safe relationships. Silencing can precipitate an internal self-negation through progressive devaluation of one's own beliefs and ideas. Jack (1993) notes that self-silencing does not directly lead to depression. A woman may become subservient to others needs if she deems caring for others in a compliant manner as a necessary prerequisite to making and maintain intimacy. Through this process the woman may feel angry, resentful, and confused. To others, she may be seen as passive, dependent, and helpless. Internally

though, fulfilling the compliant role in the hopes of securing attachment/intimacy requires cognitive and emotional effort. Through this process, the woman must actively silence her negative feelings that are socially and personally unacceptable. The self-silencing can precipitate an internal self-negation through progressive devaluation of one's own beliefs and ideas. Thus, the process of actively self-silencing may lead her to experience an internal conflict, self-condemnation, and depression.

The fifth component of the construct of marianismo, *Spiritual Pillar*, reflects the belief that Latinas are the spiritual leaders of the family and responsible for the family's spiritual religious education and growth (Castillo et al., 2010; Piña-Watson et al., 2014). Religion is commonly recognized as the organized or institutionalized expression of spiritual longing, such as rituals and behaviors that are guided by a particular religious group (Fukuyama, Puig, Pence Wolf, & Baggs, 2014). Spirituality is generally used to refer to something that gives meaning and purpose in life, or referred to as the practice of a philosophy, religion, or way of living (Department of Veterans Affairs, 2008). Latinas are religiously and spiritually diverse (Comaz-Diaz, 2014) and both are important Latina cultural values. Religiosity and spirituality are tightly interwoven within the Latino culture (García-Vázquez & Marin, 2014). Among Latinas, Catholicism remains the most widely practiced formal religion (Stohlman, 2005). For some, spirituality serves to affirm community connections and they view themselves as part of a larger force (Comaz-Diaz, 2014). The women in the family are seen as the ones who inculcate values and keep religious rituals alive (Campesino & Schwartz, 2006) and the mother normally holds the role of transmitting cultural beliefs, behaviors, identities, and traditions,

including spiritual and religious beliefs (García-Vázquez & Marin, 2014). Latina women provide encouragement for church attendance and religious practice (García-Vázquez & Marin, 2014), such as ensuring that children attend weekly mass and reach religious/cultural milestones (e.g., baptism, first communion, confirmation, and quinceañera ceremonies) (Stohlman, 2005). Among a sample of 58 Mexican descent caretakers, participants noted that their mothers had been very spiritual people and they tried to learn from them by adopting and retaining their religious beliefs and practices (Koerner, Shirai, & Pedroza, 2013). Among a group of Guatemalan women, de Gamalero et al. (2014) found that older generations of women (aged 50 or older) held solid beliefs that they should be the spiritual pillar of their family.

Interventions for Latinas with Depression

Few evidence-based or empirical approaches for treating depression among Latinas exist. Within literature, evidence based practices use various terminologies. For the purpose of this dissertation, however, the terminology used in the literature will be used interchangeably. Empirically supported treatments (ESTs), empirically validated treatments, and evidence-based treatments (EBTs) are defined as specific interventions that demonstrate efficacy for individuals with specific psychological disorders. Levant and Hasan (2008) state that two randomly controlled trials (RCTs) are required to determine if a treatment or intervention is empirically supported. Further, the authors note, that although effectiveness studies for depression exist, there is a dearth of research on how ethnic minorities and other diverse groups respond to ESTs.

One approach is Cognitive Behavioral Therapy (CBT), an empirically established intervention to treat depression among Latinas (Beck, 1995; Miranda et al., 2006; Muñoz & Mendelson, 2005). CBT is a structured, short-term, present-oriented psychotherapy for depression where the emphasis is placed on solving current problems and modifying dysfunctional thinking and behavior (Beck, 1964). The treatment focuses on distorted or dysfunctional thinking and on developing a realistic evaluation and modification of such thinking in order to improve individual mood and behavior (Beck, 1995). Organista (1996) discusses that the nature of CBT (e.g., use of manuals, homework assignments, use of chalkboards) assists Latinos in viewing therapy as a classroom experience that alleviates the stigma attached to therapy. Thus, Latinos may be more receptive to receiving such treatment.

CBT is an evidence-based treatment for improving depressive symptoms among Latinas (Miranda et al., 2003; Miranda et al., 2006; Organista, 1995; Satterfield, 1998). For instance, in a case study on a Central American woman, Organista (1995) found that the client's depression decreased from severe to moderate in a period of 16 weeks of culturally sensitive CBT group therapy. This study culturally tailored CBT to Central American women, and in this case study, the participant demonstrated symptoms of improvement. Another study also suggests that CBT group therapy is effective in reducing depression in Latinas. In a study by Satterfield (1998) with 23 low-income minority clients (12% were Latinos; 48% women), over 80% of individuals (n = 18) found the group helpful in treating their depression and about 33% of individuals experienced a reduction of depressive symptoms after completing the group. Although

Latinas (no distinction between Latino subgroups was provided) were part of the study, it is important to note that the sample size was only 12% and may not be representative of all Latinas.

In another study of CBT depression treatment among 267 women (50% Latinas, unspecified nativity or Latino subgroup), Miranda et al. (2003) found that a CBT intervention resulted in improved social functioning and reduced symptoms of depression. The intervention was provided in individual or group format, depending on the participants' availability. Sessions were shortened from twelve to eight weeks. The manual was modified for low-income Spanish-speaking medical patients and was sensitive to issues from the population served. In a 2006 study by Miranda et al., antidepressant medication and a CBT intervention resulted in clinically significant decreases in depression for all 267 low-income Latinas over a period of one year.

Other studies have found CBT to be less effective in reducing depression in Latinas (Miranda et al., 2003). Miranda et al. (2003) compared individuals receiving CBT group therapy alone and individuals receiving the CBT treatment alongside clinical case management. Findings indicate that individuals with the supplemental case management had lower dropout rates. In addition, participants with case management were associated with greater improvement in symptoms and functioning for patients whose native language is Spanish. Overall findings suggest that CBT alone was less effective than participants with the supplemental case management. Results indicate that CBT alone may not work for all Latinas and may not be the "gold-standard" for treating depression among Latinas.

Behavioral Activation (BA) has been suggested as an alternative approach to addressing depression among Latinas (Santiago-Rivera et al., 2008). In their review, Santiago-Rivera et al. advocated that BA may be as effective-- if not more effective -- than CBT due to behavioral activation's focus on environmental conditions, behavior change, and contextual factors related to depression, rather than CBTs focus on beliefs and underlying attitudes. Santiago-Rivera and colleagues indicated that aspects of the BA intervention could be adapted to incorporate specific Latino cultural values to which they later evaluated. Kanter, Santiago-Rivera, Rusch, Busch, and West (2010) developed and pilot tested a cultural adaptation of BA for Latinos with depression. The culturally adapted intervention integrated direct attempts at problem solving, identifying specific individual values, and activating behaviors that support the client's values. Results indicated that the intervention reduced depressive symptoms among Latinas (n = 10; 60% Mexican, 30% Puerto Rican; 10% US-born) and clients responded well in terms of treatment engagement and retention. The majority of clients responded to BA (i.e., decrease in depressive symptoms) and approximately half achieved remission.

Granted, there is evidence to support that culturally adapted and culturally modified evidence-based treatments (EBTs) such as CBT and BA are appropriate when treating depression among Latinas. However, these modifications were modest as described by the authors. Miranda (2008) notes that separate and modest cultural adaptations for Latinas were made such as providing care in primary health care settings and addressing mental health stigma. In a case study by González-Prendes, Hindo, and Pardo (2011), researchers made culture-based modifications to a CBT approach with a

Latino client. Cultural values such as familismo, personalismo, respeto, and machismo (gender roles) were integrated to the treatment process to provide a culturally competent treatment approach. Specifically, providing treatment in Spanish, taking acculturation into account, and by including the clients' family in therapy both directly and indirectly. Another example of cultural modifications to interventions is Organista's (1995) case study on a Central American woman. The therapist understood the client's values of familismo, respeto, and personalismo and understood the socio-political contextual factors of Central Americans. The author noted that understanding the cultural factors did not alternate the CBT case formulation, and the therapist was able to be sensitive to sociocultural factors that exacerbated symptoms and interfered with treatment. The therapist had the ability to exemplify cultural congruency and provide the client with assertiveness training, in line with Latina cultural values that are non-confrontational.

Although some scholars argue that culturally tailored interventions alone are ineffective (Miranda et al., 2006), Griner and Smith's (2006) meta analysis found that treatment approaches targeted to a specific ethnic group were four times more effective than approaches that were adapted across ethnic/cultural groups. The authors note that individuals are more likely to seek out mental health services when their values and beliefs are congruent with therapeutic interventions. In their analysis, they found that low acculturated Latina/o clients benefited the most from culturally adapted mental health interventions. The cultural adaptations were varied, including explicit incorporation of culture and values, racial/ethnic match, providing services in the client's native language, providing services in a multicultural agency, consultation with

colleagues familiar with Latino culture, provision of extra services designed to enhance client retention (e.g., childcare), and referrals to external agencies for wraparound services. Results of meta-analysis demonstrated overall positive effect of culturally adapted mental health interventions. Findings imply that cultural adaptations to mental health interventions may be more efficacious when the adaptations are specific to a particular racial/ethnic group. The authors note that optimal benefits are obtained when the treatment is tailored to a specific cultural context. Griner and Smith's (2006) note a larger issue regarding culturally adapted interventions—out of thousands of studies that examine mental health interventions, only seventy-six examined cultural adaptations. They advocate for the development of interventions that adhere to clients' cultural contexts.

To address this notion, Lara, Acevedo, Villarreal, Luna, Weckmann, and Pego (1997) developed a depression intervention culturally specific to Mexican women in Mexico City. The purpose of their intervention was to reduce symptoms of depression among this population. Prior to the development of the guide, Lara and colleagues conducted a focus group to identify ways in which depression among women is conceptualized and experienced (Lara, Acevedo, & Berenson, 2004). Results generated four general categories: the experience of depression, childhood experiences, the female social condition, and coping strategies. The majority of the participants stated that depression was present in their lives; however, prior to their participation in the focus group, they had not identified it as so. Results of the focus group indicated that participants became aware of how women are generally socialized in specific gender

female roles, how childhood events could influence the emergence of depression. Various strategies to coping with depression were also identified.

Consequently, Lara et al.'s (1997) intervention addresses the gender and sociocultural factors associated with the development and maintenance of women's depression (Lara, Navarro, Acevedo, Berenzon, Mondragón, & Rubí, 2004). The group intervention was not designed as a form of group therapy. Instead, it is a highly structured intervention conducted with small groups of women and serves more as a psychoeducational support group. The intervention model is designed within a cultural and gender perspective/framework, and it contains an educational, psychological, and group process component that promotes information, activities, and support (Lara, Acevedo, & Luna, 2001).

The educational component seeks to provide information that helps individuals understand depression within three domains: manifestation, causes, and ways of coping. Each of these aspects incorporates biological factors, childhood experiences, life events, and most importantly, gender (e.g., marianismo) and social factors. The psychological component incorporates CBT components as well as other approaches that include writing, sharing feelings, and experiences. Reduction in depressive symptoms are encouraged by detecting and correcting negative thoughts associated with depression, promoting a positive view of self, others, and their environment, increasing gratifying behaviors, facilitating the expression of negative feelings (e.g., extinguish/reduce self-silencing behavior), and encouraging an analysis of problems. Finally, the group

component involves the development of an environment of trust and support that can facilitate expressing emotions and cognitive behavioral changes.

One study to date (published twice) has evaluated the effectiveness of the depression intervention as a standalone intervention. Lara, Navarro, Rubí, and Mondragón (2003a; 2003b) evaluated the effectiveness of two levels of intervention among two hundred fifty-four women in Mexico City with and without a diagnosis of depression. Participants were divided into two groups, a group condition (GC) where they received a six-week, 2-hour group depression intervention or a minimum individual condition (MIC), a 20-minute individual session where psychoeducational materials were provided. Results indicated that both interventions were associated with a significant reduction in depressive symptoms at post-treatment evaluation and after a 4-month follow-up. Although the GC condition achieved a greater reduction of depressive symptoms than the MIC condition, no statistically significant differences were noted between the two groups.

A two-year follow-up study of 39 Mexican women residing in Mexico (Lara, Navarro, Navarrete, Mondragón, & Rubí, 2003) found that participants' depressive symptoms increased between the four-month follow up and the two-year follow-up. Despite the worsening of depressive symptoms after the intervention, symptoms from the two-year follow up did not exceed baseline evaluation levels measured at pre-treatment. Although symptoms of depression increased, participants noted that the intervention had had a great influence in their lives and the problems they faced. They indicated that they understood their problems and were able to cope with them better,

their mood had improved, they had changed their way of thinking, knew themselves better, and were more accepting of themselves. Participant feedback indicated that the number of sessions should be increased.

Lara et al. (2003) identified some limitations to their study and provided recommendations for future evaluation of the intervention's effectiveness, such as having each participant serve as her own control. Other observations of limitations to Lara et al. (2003), as noted by the researcher, is the participant's non-random assignment to each of the conditions (e.g., GC and MIC), where each condition was implemented at a different institution. Miranda et al. (2006) noted that due to Lara et al.'s (2003) limited findings, culturally tailored interventions alone might be ineffective. To address the notion of culturally tailored interventions as more appropriate for Latinas with depression, more efficacy studies are needed to demonstrate their advantages over culturally adapted interventions, in addition to replicating Lara et al.'s (1997) depression intervention.

Another critique of the study is that due to limited time constraints, researchers were unable to train personnel at each institution to conduct the intervention. Consequently, qualified psychologists with extensive experience and who had worked on the educational material were the group facilitators and the interviewers collecting pre, post, and follow-up evaluations. In the United States, Latinas may not have the access to Spanish-speaking psychologists as the participants in Lara et al.'s (2003) study. Latinas in the U.S. face mental health disparities in accessing services and treating their mental health conditions in part due to the lack of Spanish-speaking, culturally

competent clinicians (Vega & Lopez, 2001). In fact, the Surgeon General (2001) noted that linguistically and culturally skilled mental health professionals are needed. The field of psychology and public health is continually intersecting and empirically evaluating an alternative mental health workforce, such as *Promotoras*/Community Health Workers (CHWs) (Kash, May, & Tai-Seale, 2007). *Promotoras* are increasingly in high demand in the U.S. given that they are part of selected access-to-health programs (May, Kash, & Contreras, 2005). In fact, three states (Alaska, Indiana, and Texas) have systematic certification programs, which are funded by their respective states (May, et al. 2005).

Promotoras are individuals who are trusted and well-respected members of the community. They are typically female and are considered a trusted knowledge bearer by their respective communities (Ingram, et al., 2012) because they are ethnically and culturally aligned with the population served (May, et al., 2005). *Promotoras* primarily provide culturally and linguistically appropriate health education in partnership with health centers, hospitals, and universities with efforts to link the target community to various public health programs (May et al., 2005). They are considered advocates and provide referral and follow-up services when appropriate. *Promotoras* primarily focus on navigating and accessing physical health, social, and educational resources with much less emphasis on mental health concerns, such as depression. Moreover, there is minimal systematic data on the effectiveness of engaging *Promotoras* in mental health intervention research.

Promotoras are a viable workforce for several reasons. First, community members view *Promotoras* as "peers," who are more approachable than a doctor or nurse. They are linguistically and culturally skilled to communicate with community members. As such, *promotoras* are able to fill a service provider gap and may contribute to reducing mental health disparities (e.g., depression) among Latinas by encouraging Latinos to seek mental health care services. As a result of the resources and skills that *Promotoras* hold, they are increasingly integrated into the health care delivery system. *Promotoras* have gained much deserved national recognition for their role in addressing health disparities and other issues including chronic disease, prevention, and health care access (Ingram et al., 2012). Most recently, this also includes their work in addressing depression among Latinas.

Promotoras and Mental Health Research

In the past decade, research has focused on integrating *Promotoras* in mental health research and developing programs for their use with community members. Reinschmidth and Chong (2007) developed SONRISA, a mental health curriculum toolbox developed for *Promotoras* to address mental health (e.g., depression) and diabetes among Latinos. The study involved reviewing educational materials, conducting focus groups, and requesting feedback from *Promotoras* on the developed curriculum. Among the *Promotoras'* recommendations, they indicated a need to include basic information on depression, including its signs, symptoms, severity levels (e.g., mild, moderate, severe), referrals, and treatment. Promotoras also recommended the addition of culturally relevant signs and symptoms of depression as well as to address the mental

health stigma among Latino communities. The authors integrated *Promotoras*' feedback and made appropriate modifications. Therefore, the curriculum was deemed culturally appropriate for Latinas. This study is an example of the integration of *Promotoras* in the delivery of depression information to individuals who exhibit symptoms of depression. Although the study is one of the first attempts at integrating *Promotoras* in addressing depression; at this time, there are no studies evaluating the effectiveness of the SONRISA intervention.

A more recent study by Waitzkin et al. (2011) assessed the role of *Promotoras* in depression care at community health centers. After going through a structured training program, primary care practitioners (PCPs) and *Promotoras* followed a clinical algorithm. Within this algorithm, participants were randomized into enhanced care, where PCPs prescribed medications and/or arranged consultations by mental health professionals and *Promotoras* or were randomized into the combined enhanced care plus *Promotora* contextual condition. Within the latter group, *Promotoras* addressed the social contextual conditions (e.g., underemployment, inadequate housing, food insecurity, violence, etc.), which were noted as important risk factors for depression. Although a quantitative evaluation did not reveal statistically significant reduction in depressive symptoms, ethnographic results indicated positive feedback from the intervention by stakeholders including patients, *Promotoras*, PCPs, non-professional staff workers, administrators, and community advisory board members. Waitzkin et al. (2011) noted that the evaluation of innovative roles for *Promotoras* is encouraged due to the continuing unmet mental health needs of Latinas.

Promotoras are uniquely qualified to address health disparities in culturally appropriate ways due to their community membership and training, which allows them to be cognizant of intervening variables such as age, sex, culture, and acculturation (Reinschmidth & Chong, 2007). Innovative, community-based participatory approaches for the prevention and early detection of depression must be culturally appropriate (Reinschmidth & Chong, 2007). This involves providing the intervention in a way in which participants understand and enjoy in an effort to maximize learning. Knowles (1980) notes that traditional pedagogy interventions are structured in a teacher-student format (e.g., K-12 education). A traditional pedagogy format may not be as effective, particularly if a Latina has time constraints and is not used to learning from a teacher-student format.

An approach to attract and retain Latinas in mental health programs is to incorporate adult learning principles to *Promotora* led interventions. Interventions that incorporate adult learning principles may be more attractive and accessible to Latinas, primarily because adult learning theory places the responsibility of learning on the participant. At the same time, the instructor provides resources and facilitates the learning process, rather than the teacher being responsible for student learning (e.g., traditional pedagogy). Another significant aspect is that participant life experiences are very important and that the time frame for relevant application of learning must be immediate rather than postponing application for a later time (Knowles, 1980).

Peers are another central aspect of adult learning theory. Peers are vital components of the learning process where traditional pedagogy places little emphasis on

peers as resources. In the case of group interventions, group support is imperative as participants can share the struggles that they face. They can learn from others points of view, and they can learn how to problem solve based on seeing how others solve problems. In their study, (Martínez Pincay and Guarnaccia, 2007) found that participants expressed how loneliness might be harmful; they expressed that Latinas should share with other individuals and labeled being alone with sadness.

Part of Lara et al.'s (1997) depression curriculum includes carrying out self-help activities at home that were designed to reduce depressive symptoms. The women who did not carry out the activities at home stated that they did not carry out activities due to lack of time, not liking the activities, not needing to, or not having the space or privacy to write (Lara et al., 2003a and 2003b). To address the aforementioned, the design and implementation of *Promotora* led interventions should involve the use of adult learning theory. To address this notion, the modified intervention for this study incorporated activities, worksheets, and resources to enhance learning and to make it an experiential process rather than one-directional learning (e.g., teacher-student). Participants were engaged in their learning experience, through the use of adult learning principles, facilitated by *Promotoras*.

Latinos tend to be collectivistic in nature and they value interpersonal relationships (Martínez Pincay & Guarnaccia, 2007). Taking into account cultural values such as collectivism, indicates that group interventions may be the most appropriate for Latinas because they are able to self-disclose within a group setting. In a study by Martínez Pincay and Guarnaccia (2007), participants found that talk therapy was useful

because they were able to unburden themselves; they had the ability to cry to someone that would listen. In the same study, one participant expressed how loneliness could be harmful and expressed that Latinas should share with other individuals and labeled being alone with sadness. Group interventions may be the most appropriate given that Latino cultural values such as collectivism and the need for social support may be received within a group setting.

The "¿Es Difícil Ser Mujer?" (EDSM) curriculum is culturally appropriate to use with Spanish-speaking Latinas because it adheres to Latino cultural norms such as respeto, simpatía, personalismo, familismo, and Latino's collectivistic nature. The curriculum is designed in a way that is appropriate to mainly Mexican culture (as it was developed in Mexico) in terms of idioms, speech, and comedic ways of presenting information. The modified curriculum adheres to adult learning principles and engages the participants to share experiences in a group format, which some literature has noted as appropriate when working with Latinas (Stacciarini, O'Keeffe, & Mathews, 2007).

Purpose of the Study

Based on the evidence outlined, there is sufficient basis to warrant a need for evaluating culturally grounded depression interventions with Latinas. Therefore, the purpose of this study is to evaluate the effectiveness of a modified version of the Lara, et al. (1997) intervention, *"¿Es Difícil Ser Mujer? Una Guía Sobre Depresión*" (Is It Difficult Being A Woman? A Guide to Depression) (EDSM), a culturally grounded depression curriculum aimed at reducing depressive symptoms among Spanish-speaking Latinas. The secondary goal of the study was to examine whether the EDSM

intervention influenced Latina gender role beliefs (e.g., Virtuous and Chaste, Subordinate to Others, Silencing Self to Maintain Harmony).

Hypotheses

1. Hypothesis 1: There will be a decrease in PHQ-9 scores from pre to post-test.
2. Hypothesis 2: There will be a statistically significant negative rank order correlation for total depression symptoms on the PhQ-9.
3. Hypothesis 3: There will be a decrease in MBS total scores from pre to post-test.
4. Hypothesis 4: There will be no change in Family Pillar subscale scores from pre to post-test.
5. Hypothesis 5: There will be a decrease in Virtuous and Chaste subscale scores from pre to post-test.
6. Hypothesis 6: There will be a decrease in Subordinate to Others subscale scores from pre to post-test.
7. Hypothesis 7: There will be a decrease in Silencing the Self subscale scores from pre to post-test.
8. Hypothesis 8: There will be no change in Spiritual Pillar subscale scores from pre to post-test.

CHAPTER II

METHODS

The following terminology will be used to describe participants of the study. The term, *Promotoras* will be used to describe the facilitators of the depression curriculum. *Community Participants (CPs)* will be used to describe individuals from the community that participated in the depression curriculum sessions. *Community Partners* will be used to describe non-profit community organizations in East Austin, Texas that partnered with the researcher to provide a space to conduct the workshops and that assisted in recruiting *Promotoras* and *Community Participants* for the study. *Latina* will be used to describe participants who identified as Mexican/Mexican-American/Chicana, Central American, South American, Caribbean, and/or any other Latin American identity.

Procedures

Approval from the Institutional Review Board (IRB) was obtained to conduct a secondary data analysis. The School of Public Health at the Texas A&M Health Science Center (SPH) provided partial funding to collect data for this project. The present study was a partnership between the Department of Health Promotion and Community Health Sciences and the Counseling Psychology program in the Department of Educational Psychology at Texas A&M University.

Setting

Psychoeducation groups were conducted at urban, Spanish-speaking, Latina, service-oriented non-profit agencies in East Austin, Texas. Specifically, groups were conducted at La FUENTE Learning Center (La FUENTE) and their community partners

(i.e., a school, a church, and a recreation center). La FUENTE is located in the hub of a Latina/o immigrant community and serves a 100% Latina/o population. Consumers of the center are mainly monolingual Spanish-speaking and seek services such as High School Equivalency Certificate through General Education Development (GED) courses as well as English as a Second Language (ESL) classes.

A total of six groups were conducted over the course of 10 months. Two groups were conducted at a church, two groups were conducted at a school setting, one group at a recreation center, and two groups were conducted at La FUENTE.

Facilitators

A total of six Promotoras were trained to conduct the depression intervention. Of those trained, three Promotoras were involved in the facilitation of the depression intervention sessions, with one Promotora participating in the delivery to all groups. Promotoras were recruited from East Austin, Texas. All facilitators identified as Spanish-speaking, first-generation, Latinas. As part of the recruitment process, facilitators 1) expressed an interest in learning the depression curriculum and 2) expressed a desire and commitment to bring awareness of depression among Latinas in their respective communities. Convenience and snowball sampling was used to recruit facilitators. Promotoras received a $300 stipend as compensation for their participation.

Training

This researcher trained Promotoras over the course of two months, consisting of a total of six, four-hour training sessions. To ensure the fidelity of treatment delivery, Promotoras received an additional five, four-hour curriculum review sessions in which

they reviewed and practiced delivering the curriculum. In addition to curriculum training, Promotoras received training on research ethics (e.g., participant recruitment, informed consent, data collection, confidentiality, etc.) and received training on facilitation skills (e.g., presentation skills, communication, etc.). First, Promotoras participated in the depression intervention (as would be delivered to Community Participants). Second, they reviewed the curriculum to familiarize themselves with the content. Finally, they practiced delivering the intervention with the guidance of the researcher to obtain mastery.

Participants

Community participants. Sixty-five Community Participants (CPs) were recruited and registered for the EDSM depression intervention. Fifty attended at least one session, and twenty-five were designated as completing the course (i.e., attended at least four of the seven sessions) and therefore were included in the analysis of this study. Selection criteria consisted of participants identifying as Latina, feeling depressed, endorsed symptoms of depression through a standardized depression screening instrument, identified as feeling sad, stressed, lonely, feeling overwhelmed, or have lost interest in things that they normally enjoy doing and/or they expressed an interest in learning about depression among Latinas.

Community participant recruitment. Community participants were recruited from East Austin, Texas through several measures. First, La FUENTE staff was involved in identifying and recruiting members who met selection criteria and provided them with personal invitations. Recruitment involved distribution of flyers in the community (e.g.,

restaurants, Latino and mainstream grocery stores, a *tortilleria* — a location were tortillas are freshly made). The Executive Director of La FUENTE published an announcement in the local Spanish/Latino newspaper announcing the depression intervention. Lastly, participants were recruited organically (e.g., snowball and word of mouth).

Measures

The primary variables examined in this study consist of symptoms of depression and Latina gender role beliefs. The following section will describe several instruments (see Appendix A) that were utilized to examine outcome variables. Following, the intervention curriculum will be described as well as the study design and proposed data analysis.

Demographics. Participants completed a one-page demographic questionnaire containing questions regarding their age, birthplace, years living in the United States, generation status, language preference, race/ethnicity, marital status, occupation, highest level of education earned, family income, religion, comfort in utilizing mental health services (MHS), current use of MHS, chronic illness, and describing reasons for attending the depression workshop.

Depression. The nine-item Patient Health Questionnaire – Spanish Version (PHQ-9; Kroenke & Spitzer, 2001) is a self-report, brief, dual-purpose, Likert-type instrument used to measure severity of depression among adults within primary care settings. The PHQ-9 is useful due to its short administration time, and it has comparable sensitivity and specificity to other depression measures. The PHQ-9 was developed

based on the DSM-IV-TR diagnostic criteria. The PHQ-9 is a useful measure for monitoring outcomes of depression therapy given its sensitivity to change over time (Cole, Ford, & Chung, 2003; Gilbody, Richards, Brealey, & Hewitt, 2007: Huang, Chung, Kroenke, Delucchi, & Spitzer, 2006; Kroenke & Spitzer, 2002; Kroenke, Spitzer, & Williams, 2001; Löwe, Kroenke, Herzog, & Gräfe, 2003).

The PHQ-9 is composed of short statements that can be understood by a low literacy sample. Severity of depression is determined by sum of scores (0 to 27) and higher values indicate greater depressive symptomatology (Kroenke & Spitzer, 2002). The scale ranges from *never* (0) to *nearly every day* (3). Sample items include, "feeling down, depressed, or hopeless," "feeling tired or having little energy," and "little interest or pleasure in doing things." Easy to remember 5-point threshold scores indicate severity of depression: no depression (0-4), mild depression (5-9), moderate depression (10-14), moderately severe depression (15-19), and severe depression (20-27). The PHQ-9 has good internal consistency and reliability with coefficients ranging from .71 to .89 with various samples. Test-retest reliability correlations appear to be acceptable. Both the English and Spanish version of the PHQ-9 has been validated among Latinas (Merz, Malcarne, Roesch, Riley, & Sadler, 2011).

Modification of the Spanish PHQ-9.The Spanish PHQ-9 has been validated with Latinas in Spain, Honduras, Chile, Costa Rica, and the United States (Diez-Quevedo, Rangil, Sanchez-Planell, Kroenke, & Spitzer, 2001; Huang, Chung, Kroenke, Delucchi, & Spitzer, 2005; Reuland et al., 2009; Wulsin, Somoza, & Heck, 2002), yet various versions of the form have been used and none were specific to Latinas in Central Texas.

Latinas are a heterogeneous group and the Spanish language differs by country and region in terms of dialect, cultural nuances, and vocabulary. Sensitivity of the instrument was needed to ensure the validity of the responses of the community participants in the Central Texas region.

The Spanish version of the PHQ-9 was modified for the current study in a couple of ways. First, symptoms of depression were assessed over the course of one week, versus two weeks as the PHQ-9 is currently designed. The purpose of modifying the instrument was to allow participants to assess their depressive symptoms on a weekly basis and to adhere to the single-case multiple-baseline across subjects research design. Second, seven versions of the Spanish PHQ-9 are currently available and they were reviewed and condensed into one measure. Although the item content of all seven versions is the same (i.e., measuring the same thing), they each vary slightly in terms of grammar, sentence structure, clarity, and anchors. For example, "*Nada*" and "*Para Nada*" both categorize a score of "0" while a score of "3" is measured by "*Más de la Mitad de los Días*" and "*La Mayoría de los Días*" anchors. These are slight variations that could potentially impact the clear understanding of the statements and the accuracy in participant responses.

To preserve the validity of the instrument and as part of the modification process, each *Promotora* was provided with the seven versions of the Spanish PHQ-9 (see Appendix B) and they individually selected the version that they best understood. They did this by evaluating individual items on each of the measures for clarity, grammar, logical sense of the statements, and anchors. As a group, consensus was reached as to

which version was to be used (e.g., Version 3). Thereafter, individual items on the selected version were discussed and evaluated with the researcher (native bilingual) and two other community members who are also native bilingual speakers to ensure accuracy of translation and back-translation. Table 1 demonstrates an example of the grammatical differences on item number five of the PHQ-9 among all seven versions. Finally, each item was reviewed until all the items and anchors were clearly understood by the *Promotoras*. The final version of the modified Spanish PHQ-9 was used in the study to assess weekly depressive symptoms among the community participants. As a group, Promotoras were trained on research/study design and instrument development, and their vital role within research studies (e.g., Community-Based Participatory Research).

Table 1

Sample Item - Grammatical Differences in the Spanish PHQ-9

Item #5 on the PHQ-9, Spanish Version.	
"Poor appetite or overeating."	
Sample #1	**Tengo** poco apetito o como en exceso.
Sample #2	Tengo poco apetito o **como** en exceso.
Sample #3	**Tener** poco apetito o **comer** en exceso.
Sample #4	**Con** poco apetito o ha **comido** en exceso.
Sample #5	**Pobre de apetito** o comer en exceso.
Sample #6	**Tiene** poco apetito o **come** en exceso.
Sample #7	**Tengo** poco apetito o **comer** en exceso.

Self-reported depression events. Participants were asked to indicate (Yes/No) if they experienced an event during the week that caused them to feel depressed (e.g., receive bad news, experienced something upsetting). Participants reported experiencing a depressive event on a weekly basis. Number of depressive events was calculated by

adding the number of Yes responses throughout the 7-week period for a total of seven possible depressive events.

Gender role beliefs and cognitive enculturation. The Marianismo Beliefs Scale (MBS: Castillo et al., 2010) is a 24-item scale used to measure levels of traditional Mexican American woman gender role beliefs and is also a measure of cognitive enculturation. The items assess traditional Mexican American woman gender role beliefs and values through questions that focus on *familismo*, *respeto*, and *simpatía*. This measure identifies five factors of *Marianismo*, including Family Pillar, Virtuous and Chaste, Subordinate to Others, Silencing Self to Maintain Harmony, and Spiritual Pillar. Each item is measured using a Likert-type scale and responses range from *Strongly Disagree* (1) to *Strongly Agree* (4). Mean scores of 2.5 or higher indicate an adherence to traditional gender role beliefs. The MBS has good internal consistence with Cronbach's alpha of .89 and subscale scores of .77 (Family Pillar), .79 (Virtuous and Chaste), .76 (Subordinate to Others), .78 (Silencing Self to Maintain Harmony), and .85 (Spiritual Pillar).

Intervention Curriculum

A modified version of the *"¿Es Difícil Ser Mujer? Una Guía Sobre Depresión*" (Is It Difficult Being A Woman? A Guide to Depression) (EDSM: Lara et al. 1997), depression curriculum was used as the intervention for this study (see Appendix C). Permission to use the modified version of EDSM was provided by Project Concern International through the program, Project HEAL (Health Education and Action for Latinas). The following sections describe the original curriculum, the rationale and

modifications made to the original curriculum, and examples of how the curriculum was modified for this study.

Original curriculum. The EDSM is a depression educational program incorporating the diagnostic criteria of the Diagnostic and Statistical Manual of Mental Disorders, with a specific focus on the social condition of women (e.g., gender and cultural factors) that influence depressive symptoms among women residing in Mexico City, México. All of the curriculum materials were developed in Spanish and the book is illustrated with caricatures (e.g., comic book model), language, and idioms that are understood by individuals with low-literacy. The depression intervention is delivered over seven-weeks in sessions that last approximately two hours each for a total of twelve instructional hours (see Table 2).

Table 2

EDSM Content by Module

Session 1	**Introduction: What is EDSM?**
	Session 1 provides the participants with an overview of the EDSM curriculum. The purpose of this session is to introduce the topics that will be addressed throughout the intervention and entice participants to engage in the EDSM intervention. During this session, participants engage in ice breaker activities to begin building rapport, they complete pre-test questionnaires, they discuss introductory concepts to gender role beliefs and their impact on mental health, develop a self-care plan, and sign a contract with themselves, indicating their commitment to participating in the training.
Session 2	**Depression, Cognitions, and Cultural Stigma**
	Session 2 provides participants with an overview of depression symptoms and cognitions of depressed individuals. Depression/mental health stigma within Latina/o culture is discussed. Participants engage in an icebreaker activity to continue to build rapport. Participants review self-care plan from previous session. Participants set group rules/agreements (e.g., confidentiality) to be adhered to throughout the course of treatment.
Session 3	**Contributing Factors to Depression**
	Session 3 provides an overview of contributing factors to depression (i.e., childhood history, life events, biological factors, social condition of women, and social factors). Participants review assignments from previous week and are assigned new assignments at the conclusion of the session. Participants engage in guided visualization that prompts childhood memories and as a group, discuss its impact on adulthood.
Session 4	**Gender Roles and Sexuality**
	Session 4 provides basic information on gender roles and how these may affect individuals in their adult life. Female sexuality, myths about sexuality, homosexuality, and how male and female gender roles are explored. Differences between sex and gender are discussed and a case scenario involving gender roles and sexuality is presented. Participants engage in review of their self-care plans and are provided with homework assignments.
Session 5	**Self-Esteem and Problem Identification**
	Session 5 focuses on identifying the various institutions that mark social and gender norms within Latina/o culture (e.g., *telenovelas*, family, church, etc.). Participants discuss how they learn about love, suffering, beliefs about what it is to be a woman, etc. Participants engage in an activity that serves as a catalyst to cognitive reframing. Participants identify characteristics within themselves that they would like to change or "leave behind" while embracing positive characteristics that allow them to problem solve. Participants are exposed to materials that foment positive self-esteem and they are provided with an assignment that allows them to address events in their lives that cause sadness, fear, or anger in their lives.
Session 6	**Cognitive Reframing and Problem Solving**
	Session 6 focuses on cognitive reframing and problem solving. Participants are introduced to a series of engaging activities that focus on reframing how problems are viewed. First, participants identify the different types of problems that Latina women face (e.g., economic, communication, family, gender, etc.). Participants learn to identify problems that are within and beyond their scope of problem solving. Participants engage in three main activities: discussion of the "Old and Young Woman" optical illusion, the Young and Old Lady illustration, and Duncker's Candle Problem. Participants are asked to identify a problem they are currently facing and asked to develop a plan of action to solve that particular problem.
Session 7	**Depression Treatment and Graduation**
	The last session of the intervention focuses on summarizing information learned throughout the intervention and ways of coping with depression are addressed. Participants are taught a handmade craft (e.g, jewelry making) as an example of a depression coping mechanism and community resources are discussed (e.g, psychotherapy). Participants engage in a graduation ceremony where they are presented with certificates of completion and they engage in a potluck celebration.

The four main categories addressed in the curriculum involve the following: 1) the depression experience; 2) childhood history; 3) social condition of women; and 4) coping strategies. The subcategories of the depression experience (Category 1) involve recognizing depression as an illness, reviewing symptoms of depression, and defining patterns or styles of thinking among depressed women. Category 2, according to the authors, is based on psychological theories that explain the relationship between childhood experiences and the development of depression in adulthood. Such experiences may involve the loss of important figures, the development or underdevelopment of nurturing relationships, and parents' placing robust responsibilities on children at an early age (e.g., cooking, cleaning, and taking care of younger siblings) because of their gender.

The social condition of women (Category 3) focuses on the socialization of women's gender roles and the factors that may put women at risk for depression. Gender role factors may include learning to be passive, self-sacrificing, submissive, considered less valuable, little emphasis placed on their education, and holding major responsibilities in the home. The socialization of gender roles and depression is addressed by focusing on women's life stages such as adolescence, sexuality, partner relationships, maternity, menstruation, post-partum depression, and menopause. Alcoholism and violence and the duality of being a homemaker and/or working outside the home are discussed. The final component of the EDSM curriculum (Category 4) focuses on coping strategies, self-help, symptom management, and where to seek resources in their communities. Some of the self-help strategies include cognitive

restructuring (a CBT element), catharsis (e.g., journaling, writing a letter), and developing changes in their beliefs and behaviors (also CBT).

Rationale and modification to Lara et al. curriculum. The ESDM was developed in Mexico for women residing in Mexico. As such, modifications were needed for its use with Latinas residing in the United States, particularly recent immigrants (López-Arenas & Cano-Hays, 2005, unpublished). The rationales for modifying the curriculum are discussed subsequently. The first is to tailor the curriculum to meet the needs of immigrant and US born Latinas. The life experiences of Latinas in the US are different than those of *Mexicanas* in Mexico. For instance, women of Mexican or Central American descent who migrated to the US will have different life experiences than Mexican women who have never experienced cross border migration (Berger & Weiss, 2006; Cervantes, Mejía, & Mena, 2010; Kaltman et al., 2011).

The second rationale for tailoring the EDSM curriculum was to develop a detailed protocol/manual that can be readily used by *Promotoras*.to retain the treatment fidelity, such as the protocols used by Waitzkin et al., 2011, Keller et al., 2012, and the annotated bibliography noted in WestRamus et al., 2012. The third reason for modifying the EDSM curriculum is due to the lack of accessibility to the curriculum. The original EDSM curriculum requires that each participant receive a copy of the book to read in session. Unfortunately, the book and training manual is out of print and there are insufficient copies for each group member to use. The curriculum was modified to include activities that convey the same message in lieu of reading the book.

In response to the limited access to the EDSM book and to attract and retain Latinas in the intervention, adult learning theories (Knowles, 1980) were incorporated into the modified curriculum. In a previous section, *promotoras* and mental health research, the importance of incorporating adult learning theory (ALT) was addressed. Mainly, ALT places the learning responsibility on the participant, which allows for participants to share their life experiences with peers, and learn new concepts through their shared experiences. Moreover, learning is more appealing if it is directly relevant to the learner's interests and goals (Nebeker & López-Arenas, 2016).

Finally, the curriculum was modified through the addition of an introductory session, to account for logistical issues related to participant recruitment, retention/attrition, and the implementation of a new program in the community. It is well documented that the attrition rate for engagement in mental health services among ethnic minorities, including Latinas is high, including perceptions, beliefs, and assumptions of mental health (Barrett et al., 2008; Kouyoumdjian, Zamboanga, & Hansen, 2003; Miranda et al., 1996). Specific rationale for adding an introductory session is subsequently described.

The following are two examples of modifications made to the curriculum (see Appendix C). The first modification addresses the logistical aspects of implementing a program in a Latina community (e.g., recruitment, attrition). In Lara et al.'s (1997) intervention, the overarching objective of the first session is to read and discuss the symptoms of depression and the ways in which depressed people think. In the modified curriculum, the overarching goal of the first session is to engage the participants and

obtain their "buy-in" to decrease subsequent attrition, and to encourage them to recruit other participants in the case that attendance numbers are low (e.g., two participants instead of the minimum six required).

The second and most notable modification addresses the notion of cognitive restructuring, as Beck (1995) emphasizes its importance in improving mood and behavior. Session five of the original intervention focuses on examining participants basic beliefs about love, suffering, and gender roles through text reading and group discussion. An additional objective is to identify ways in which each participant perceives the world, how that contributes to her depressed mood, and alternatively, how to engage in positive and more accurate ways of thinking (e.g., cognitive restructuring).

In the modified curriculum, cognitive restructuring is also addressed. However, the difference between the two is *how* the objective is approached. Organista (1996) notes that Latinas are more receptive to therapy if it is viewed as a classroom experience, which is consistent with adult learning principles to maximize learning. For example, the focus of learning is centered not on the person, but on problem solving, engaging peers as part of the learning process, and for the facilitator to provide resources that assist the learning process, placing greater responsibility on the learner. The modified curriculum incorporates adult learning principles to address the objectives of the original curriculum by engaging participants in experiential activities that focus on cognitive restructuring. The objective is reached through a set of classic problem solving activities that they solve individually and as a group. Through the set of activities and debriefing at the end of the session, participants have the opportunity to reflect on their reactions to the in-

session problem solving activities and to connect their reactions to how they problem solve in their daily lives.

The process of observing one's thinking, metacognition, facilitates an individual's ability to influence and restructure thought processes (Güss & Wiley, 2007). The facilitator communicates to the group that observing their own rigidity in thinking may impact their mood and thus, participants are encouraged to restructure the way in which they perceive their environment for healthier coping and decrease depressive symptoms. In a study by Rivera, Elliott, Berry, and Grant (2008), caregivers who received problem-solving training reported significant decreases in depression, health complaints, as well as dysfunctional problem-styles over time. In a similar study, caregivers who received problem-solving treatment reported a significant linear decrease in depression over time and displayed an increase in constructive problem-solving styles over the year (Elliott, Berry, & Grant, 2009).

Study Design

Defining single-case research design. For the purposes of this research study, a multiple-baseline single-case research design was used. Single-case research design (SCR) is an experimental alternative approach to group research that is firmly founded in the scientific method and that has several major advantages for applied clinical research (Barlow & Hersen, 1973). The purpose of SRC is to document causal or functional relationships between independent and dependent variables (Horner, Carr, Halle, McGee, Odom, & Wolery, 2005).

The A-B design. The A-B experimental single-case research design is the most basic of all research designs (Barlow & Hersen, 1973). The A-B design consists of the initial baseline phase (A), which will establish the natural occurrence of the targeted behavior prior to the intervention (e.g., depression, gender role beliefs, depression knowledge). Baseline or pre-treatment measurements are generally continued until a stable pattern emerges. A minimum of three separate observation points is required to establish a trend in the data (Barlow & Hersen, 1973). Following the pre-treatment phase, the Intervention (Phase B), consisted of the implementation of the depression curriculum. Changes to the targeted behavior (i.e., depression, gender role beliefs) will be interpreted against the benchmark of pre-treatment responses (Morgan & Morgan, 2009). Relevant dimensions of behavior (e.g., rate, duration) were recorded systematically and repeatedly for each subject throughout Phase A and B of the study.

Three basic assumptions of single-case research. Single-case research (SCR) holds three basic assumptions: 1) emphasis is placed on observation and measurement of behavior in individual subjects; 2) a continuous measurement strategy is warranted because behavior is a continuous phenomenon that changes progressively with time; and 3) individuals serve as his or her own control. Because behavior is measured at the individual level, repeated measures allows the individual to serve as their own comparison because behavioral measures can be taken prior to, during, and after the introduction of the intervention. The repeated measures assumption is a key feature of SCR and is viewed as essential to effectively interpret behavior change in individuals (Boersma et al., 2003; Morgan & Morgan, 2009). Morgan and Morgan (2009) note that

due to various measurements of the relevant dependent variable will be taken during all phases of the study, the researcher has the opportunity to directly and continuously assess patterns and degree of behavioral variability throughout the study (Morgan & Morgan, 2009).

Multiple-baseline across individuals research design. A multiple-baseline across individuals (or subjects, clients) SCR design is common among clinical settings. The design is useful in situations where several individuals in the same environment demonstrate similar behavioral symptoms (Morgan & Morgan, 2009). The purpose of introducing an intervention to a community is to produce a reliable change in the target behavior (i.e., decrease depression) that will prevail beyond the individuals' participation in the intervention workshops.

The multiple-baseline design approach involves the replication of several A-B phase changes across more than one individual and they are implemented in a staggered fashion over time (Morgan & Morgan, 2009). Morgan and Morgan (2009) note that:

> Each replication of the intervention allows one to draw an inference about the internal validity of the intervention because the staggered nature of the replications eliminates alternative explanations for behavior change. In addition, the multiple-baseline across individuals' design contributes to the external validity of an intervention by way of its numerous inter-subject replications (p. 134).

Through the process of replication of a treatment or intervention across several individuals, treatment effectiveness can be assessed without concern about the logistical

or ethical concerns of other approaches. In essence, no withdrawal design (A-B-A) or experimental conditions are required to demonstrate the effects of the intervention (Kazdin, 1982; Kazdin, 2011; Morgan & Morgan, 2009). Hence, one of the benefits of the design is that if numerous replications of the study are available, then the researchers can be more confident about the effects of the intervention and the general utility of the treatment (Morgan & Morgan, 2009). Levesque, Savard, Simard, Gauthier, and Ivers (2004) used a similar research design to assess the efficacy of cognitive therapy for depression among women with metastatic cancer.

Rationale for the use of SCR: Group research vs. SCR. Although single-case research has been overshadowed by large-group, randomized control trials (RCTs), SCR have emerged as an important alternative (Morgan & Morgan, 2009). SCR methods can be a cost-effective approach to identifying behavioral and educational interventions that are appropriate for large-scale analysis (Horner et al., 2005). According to Morgan and Morgan (2009), SCR offers substantial advantages over large-group designs, particularly for researchers and practitioners who conduct empirical studies of clinical interventions in an applied behavioral health and mental health setting.

Finally, the movement towards using evidence-based treatments promotes the use of single-case research and multiple-baseline across individuals' designs to assess interventions (Morgan & Morgan, 2009). This may be particularly important in studying psychological interventions with Latinas. The literature indicates that Latinas have a high attrition rate when receiving mental health services. Attrition rates may be attributed to extraneous circumstances such as lack of transportation, childcare,

uninsured status, inability to pay for the cost for services, or little to no mental health literacy. The use of single-case research with Latinas is one of the most appropriate research designs, given that each individual serves as her control and thus, if attrition occurs, the integrity of the research is not compromised. For example, if a community participant misses a session or does not attend the depression workshops on a consecutive basis, the validity of the study is retained.

Research Design for this Study

A total of six groups were recruited for the study, each with an average of 6-10 community participants per group, and led by two *Promotoras* trained in the curriculum. Participants were administered questionnaires on a weekly basis. The demographic questionnaire, the PHQ-9, and the MBS scale were administered at pre-treatment at least one week before the start of the intervention. Thereafter, participants completed the PHQ-9 on a weekly basis (Sessions 1-7) prior to the start of each session. The MBS was administered at Session 1, Session 4, and Session 7. There was a total of one pre-treatment data point for the following measurements: depression symptomatology (PHQ-9), number of depressive events, and Marianismo beliefs (MBS).

Data Analysis

In order to test hypotheses (Hypothesis 1, Hypotheses 3-8), independent sample t-tests using the Statistical Package for the Social Sciences (SPSS; Version 21.0) was used to examine changes in mean scores for depression (PHQ-9), MBS total scores, and changes in MBS subscale scores (e.g., Family Pillar, Virtuous and Chaste, Subordinate to Others, Silencing the Self, and Spiritual Pillar). This statistical analysis was selected

as an appropriate statistic to test changes in mean scores within the variable across time, pre and post-test.

Hypothesis 2 was tested using Kendall's Tau statistical analysis using Gnu R with Kendall library. Kendall's Tau is a non-parametric correlation performed on rank data. It is comparable to Spearman's rank correlation and Pearson r correlation, and generates *p* values at a .01 or .05 level to determine statistical significance in the strength of dependence between two variables. Kendall's Tau is a measure of correlation and measures the strength of the relationship between two variables. Values range between -1 and +1, where a positive correlation indicates that the ranks of both variables increase together while a negative correlation indicates that the rank of one variable increases while the other one decreases. The significance or alpha level for all analyses in this study was set to .05. Kendall's Tau is an appropriate statistical analysis for small sample sizes, particularly for single-case research designs.

CHAPTER III

RESULTS

Operationalization

The following terminology is used to describe study population and findings. Participant engagement was classified into the following three categories: Actively Engaged, Partially Engaged, and Not Engaged. Actively Engaged (AE) participants are individuals who completed the course and received a certificate of completion. AE individuals are also referred to as “completers.” Partially Engaged (PE) participants are individuals who attended at least one session but did not complete the course. PE participants are also referred to as “non-completers.” Not Engaged (NE) participants are individuals who registered for the course, but did not attend any sessions.

Missing Data and Participant Attrition

Attrition is common in community-based, culturally specific interventions with hard-to-reach populations such as Latinas. Attrition can have a detrimental impact on data analysis and interpretation. Sixty-five participants registered for the course and fifty attended at least one session. However, premature departure from the intervention yielded a total of twenty-five participants who successfully completed the EDSM intervention. Participants’ reasons for premature departure included schedule conflicts, inability to commit to a seven-week course, duration of each workshop (e.g., two hours), transportation concerns, work or home responsibilities, did not feel comfortable within a group setting, were not interested in a depression intervention, or did not provide reasons

for attrition. Consequently, data from participants who failed to complete all required phases of a study and who did not complete the minimum data points for each phase were not available for analyses.

Analytic procedures to test the primary hypotheses of the study included t-tests and Kendall's Tau. Post-hoc analyses were conducted on other clinically important variables to further our understanding of the sample. Results for this chapter will be presented in the following order: sample characteristics, preliminary analysis, Kendall's Tau, and post-hoc analyses.

Sample Characteristics

Total sample. Descriptive statistics and frequencies were used to characterize the information on socio-demographic indicators. Tables 3 through 12 display the descriptive statistics for the demographic variables of the two study groups, Actively Engaged and Partially Engaged participants. The total sample at pre-treatment consisted of 65 Latinas. Participants ranged in age from 18 to 68 years old with a mean age of 39.47 (SD = 11.33). Consistent with the demographic region in East Austin, Texas, 64.6% (n = 42) of the participants identified as Mexican/Mexican American/Chicana. The number of years living in the US ranged from 0 to 34 years old with a mean of 14.09 years (SD = 7.61). Participants had a mean education level of 9.65 years (SD = 3.08) and earned a yearly income of $19,105 ($SD$ = $10,153). Sixty-eight percent preferred to speak in Spanish (n = 44) and 41.5% (n = 27) identified as first-generation. Fifty-two percent (n = 34) were partnered, 41.5% were married and 10.8% were living

with a partner. Thirty-nine percent (*n* = 25) identified as homemakers. Participant's predominant religious affiliation was Catholic 46.2% (*n* = 30).

Participants who completed the study (actively engaged). Completion of the intervention was defined as attendance in at least four of the seven intervention sessions and attending the sixth and/or the seventh session. Actively Engaged participants attended 5.72 (*SD* = 1.02) sessions. Participants who completed the training were awarded with a professional and elaborate certificate of completion, which is highly important to this population given their limited education. Participants who completed the EDSM depression intervention (*n* = 25) ranged in age from 26 to 63 years old with a mean age of 40.64 (*SD* = 10.38). Consistent with the demographic region in East Austin, Texas, 92.0% (*n* = 23) of the participants identified as Mexican/Mexican American/Chicana. The number of years living in the US ranged from 0 to 34 years old with a mean of 15.76 years (*SD* = 7.98). Participants had a mean education level of 9.37 years (*SD* = 3.70) and earned a yearly income of $22,029 (*SD* = $8, 980). In terms of language preference, 100% of the group preferred to speak in Spanish (*n* = 25) and 64% (*n* = 16) identified as first-generation. Eighty percent (*n* = 20) of the participants were partnered; specifically, 60% were married and 10.8% were living with a partner. Sixty-four percent (*n* = 16) identified as a homemaker while 16% (*n* = 4) and 12% (*n* = 3) identified as working full time and part time, respectively. Participant's religious affiliation was predominantly Catholic 80% (*n* = 20). Participants' religious engagement ranged between not attending church and attending church twice a week (e.g., Sunday and Wednesday). Of those classified as religiously engaged, 44 % (*n* = 11) attended

church at least once per month. Twelve percent ($n = 3$) stated no religious engagement, and 44% ($n = 11$) did not report their religious engagement. Participants reported an average of 2.72 depressive events ($SD = 1.95$) throughout the course of the 7-week intervention.

Participants who did not engage in the study (not engaged). Participants who did not engage in the intervention did not complete questionnaires; therefore, no demographic data was generated for these individuals.

Table 3

Demographic Means and Standard Deviations by Level of Engagement

Variable	Partially Engaged (Non-Completers) (N = 25)		Actively Engaged (Completers) (N = 25)	
	M	*SD*	*M*	*SD*
Age	38.0	12.5	40.64	10.38
Education	9.94	2.3	9.37	3.70
Income	$15,011	$10,726	$22,029	$8,980
Years in the US	11.78	6.59	15.76	7.98

Note. Annual income is reported.

Table 4

Number of Sessions Attended by Level of Engagement

Variable	Partially Engaged (Non-Completers) (*N* = 25)		Actively Engaged (Completers) (*N* = 25)	
	M	*SD*	*M*	*SD*
Sessions Attended	2.16	3.80	5.72	1.02

Note. Intervention consisted of seven weekly sessions.

Table 5

Group Size by Level of Engagement

	Partially Engaged (Non-Completers) (*N* = 25)		Actively Engaged (Completers) (*N* = 25)	
Variable	*N*	*%*	*N*	*%*
Group 1	5	20.0	7	28
Group 2	1	4.0	1	4.0
Group 3	-	-	3	12.0
Group 4	4	16.0	4	16.0
Group 5	11	44.0	5	20.0
Group 6	3	12.0	5	20.0

Table 6

Ethnicity by Level of Engagement

Variable	Partially Engaged (Non-Completers) (N = 25)		Actively Engaged (Completers) (N = 25)	
	N	%	N	%
Ethnicity				
Mexican/Mexican American/Chicana	19	76.0	23	92.0
Central American	-	-	1	4.0
South American	-	-	1	4.0
Caribbean	1	4.0	-	-
Unknown	5	20.0	-	-

Table 7

Birth Origin by Level of Engagement

	Partially Engaged (Non-Completers) (*N* = 25)		Actively Engaged (Completers) (*N* = 25)	
Variable	*N*	%	*N*	%
Birth Origin				
Colombia	1	2.0	1	4.0
Mexico	18	72.0	22	88.0
Puerto Rico	1	4.0	-	-
United States	1	4.0	2	8.0

Table 8

Language Preference and Generation Status by Level of Engagement

	Partially Engaged (Non-Completers) (*N* = 25)		Actively Engaged (Completers) (*N* = 25)	
Variable	*N*	%	*N*	%
Language preference				
Spanish	19	76.0	25	100.0
English	1	4.0	-	-
Unknown	5	20.0	-	-
Generation				
1st	11	44.0	16	64.0
2nd	9	36.0	7	28.0
3rd	0	0.00	2	8.0
Unknown	5	20.0	-	-

Table 9

Marital Status by Level of Engagement

	Partially Engaged (Non-Completers) (N = 25)		Actively Engaged (Completers) (N = 25)	
Variable	N	%	N	%
Marital status				
Single	1	4.0	2	8.0
Married	12	48.0	15	60.0
Separated	4	16.0	-	-
Divorced	1	4.0	2	8.0
Living with partner	2	8.0	5	20.0
Widowed	-	-	1	4.0
Unknown	5	20.0	-	-

Note. Single status refers to never married.

Table 10

Occupation by Level of Engagement

	Partially Engaged (Non-Completers) (*N* = 25)		Actively Engaged (Completers) (*N* = 25)	
Variable	*N*	%	*N*	%
Occupation				
Full-time[1]	2	8.0	4	16.0
Part-time[2]	2	8.0	3	12.0
Homemaker[3]	9	36.0	16	64.0
Student[4]	1	4.0	-	-
Unemployed[5]	1	4.0	-	-
Self-employed[6]	1	4.0	-	-
Unknown[7]	5	20.0	-	-
3 & 4	1	4.0	1	4.0
3 & 5	1	4.0	-	-
1 & 4	1	4.0	-	-
1 & 3	1	4.0	-	-
2 & 6	1	4.0	1	4.0
2 & 4	1	4.0	-	-

Note. 1 = full-time employment; 2 = part-time employment; 3 = homemaker; 4 = student; 5 = unemployed; 6 = self-employed; 7 = unknown.

Table 11

Religious Affiliation by Level of Engagement

Variable	Partially Engaged (Non-Completers) ($N = 25$)		Actively Engaged (Completers) ($N = 25$)	
	N	*%*	*N*	*%*
Baptist	1	4.0	-	-
Catholic	10	4.0	20	80
Christian	3	12.0	3	12.0
Pentecostal	1	4.0	1	4.0
Evangelist	1	4.0	-	-
Jehovah's Witness	3	12.0	-	-
Missing	7	28.0	1	4.0

Table 12

Religious Engagement

Variable	Attend Church (N = 25)	
	N	*%*
Engaged	11	44.0
Not Engaged	11	44.0
N/A	16	32.0

Note. Religious engagement is defined as attending church.

Table 13

Number of Depressive Events Throughout Treatment

	ID	# Depressive Events
Group 1		
	8	6
	21	0
	27	5
	28	4
	35	4
	37	4
	41	2
Group 2		
	2	7
Group 3		
	16	4
	30	0
	51	5
Group 4		
	3	2
	5	2
	11	1
	46	5
Group 5		
	17	1
	25	2
	36	2
	39	1
	47	2
Group 6		
	7	4
	9	2
	18	0
	20	2
	33	1

Preliminary Analyses

Correlations across study variables. Correlations were computed for the self-report and study variables (see Table 14). Level of treatment engagement (e.g., Actively Engaged vs. Partially Engaged) was significantly and positively correlated with the number of sessions attended ($r = .935$, $p < .001$), pre-treatment depression ($r = .375$, $p = .026$), total number of depressive events ($r = .425$, $p = .002$), pre-treatment depression severity ($r = .342$, $p = .048$), pre-treatment MBS ($r = .367$, $p = .039$), and Session 1 family pillar, ($r = .368$, $p = .025$). Compared to Partially Engaged (Non-Completers) individuals Actively Engaged (Completers) participants had higher depression scores at pre-treatment, reported a greater number of depressive events and experienced higher pre-treatment depression severity. AE participants-reported more traditional gender role beliefs at pre-treatment, particularly traditional beliefs regarding family values.

Table 14

Correlations Across Study Variables

	1	2	3	4	5	6
1. Level of treatment engagement	1					
2. Number of sessions attended	.935**	1				
3. Pre-treatment – PHQ9	.375*	.398*	1			
4. Session 1 – PHQ9	.266	.276	.850**	1		
5. Session 7 – PHQ9	-.53	.042	.412	.484*	1	
6. Total depressive events through treatment	.425**	.482**	.329	.368*	.520**	1

Note. *$p < .05$. **$p < .01$. ***$p < .0001$

Clinical depression among participants. This section will identify the variables examined for clinical depression, will describe the criteria for clinical depression and proposed treatment, and will report findings for this study. Clinical depression among participants was examined for both PE and AE individuals. Measurements were taken at both pre-treatment and Session 1. Clinical depression was determined by a total score of 10 or higher on the PHQ-9 (Kroenke & Spitzer, 2002). Kroenke and Spitzer (2002) suggest a screening cut off point of a score of 10 or higher (e.g., moderate depression severity and higher), which has sensitivity and specificity of 88% and 7.1 likelihood ratio for Major Depressive Disorder (MDD). Proposed treatment actions at the moderate depression level include creating a treatment plan, recommending counseling, follow-up, and/or pharmacotherapy.

Kroenke and Spitzer (2002) recommend the following treatment actions based on PHQ-9 total scores. PHQ-9 scores between 1 and 4 classify as no depression, therefore no treatment actions are recommended. PHQ-9 scores of 5 to 9 are classified as Mild Depression Severity and warrant observation and re-administration of the PHQ-9 questionnaire at follow-up. Scores between 10 and 14 classify as Moderate Depression Severity, which warrant treatment, potential counseling, and follow-up and/or pharmacotherapy. Moderately Severe Depression (15-19 PHQ-9 total scores) suggests urgent psychotherapy and/or medication treatment. PHQ-9 scores between 20 and 27 are deemed as Severe Depression Severity and warrant immediate pharmacotherapy and an expedited referral to a mental health specialist for psychotherapy if the individual has severe impairment or is not responsive to therapy.

MDD was measured at both pre-treatment and Session 1. Thirty percent (n = 15) of non-completers were classified as having MDD at pre-treatment (e.g., clinically depressed) and 32% (n = 16) at Session 1. Forty-two percent (n = 11) of completers were clinically depressed both at pre-treatment and Session 1. Table 15 provides a comparison between completers and non-completers.

Table 15

Clinically Depressed Participants Among Treatment Completers and Non-Completers

	Partially Engaged (Non-Completers) ($N = 25$)		Actively Engaged (Completers) ($N = 25$)	
Variable	*N*	%	*N*	%
Pre-treatment	15	30.0	11	42.0
Session 1	16	32.0	11	42.0

Note. Depression determined by a PHQ-9 total score > 10 as recommended by Kroenke and Spitzer (2002).

Group differences, completers vs. non-completers. A series of t-tests were conducted to determine if Actively Engaged participants were different than Partially Engaged participants (non-completers). Statistical significance was set at $p < .05$. In addition to *p* values, an effect size is calculated to determine the size or magnitude of an effect. Effect size is calculated using Cohen's *d* statistic (Cohen, 1988). The threshold for interpreting effect size are as follows: $d = .2$ (small effect size), $d = .5$ (medium effect size), and $d = .8$ (large effect size).

Chi-Square Test of Independence, Completers vs. Non-Completers

Clinical depression. A χ^2 test of independence was performed to examine the relationship between clinical depression among treatment completers versus non-completers. The relationship between these variables was statistically significant, χ^2 (2, N = 34) = 6.66, p = .036. Completers of the EDSM intervention were more likely to be clinically depressed. Results indicate that among frequency of depressive symptoms, treatment completers reported statistically significant higher scores (M = 15.40, SD = 9.56) compared to non-completers (M = 7.43, SD = 4.82), t(20.98) = -2.86, p = .009 (Cohen's d = 1.05).

Gender role beliefs. The Family Pillar and Spiritual Pillar subscales of the MBS assessed aspects of gender role beliefs. Both Family Pillar (at pre-treatment Session 1 and Session 7) and Spiritual Pillar (at Session 7) were statistically significant. Family Pillar refers to the belief that Latina women are the main source of strength for her family and that she is responsible for keeping the family happy and unified. Treatment completers reported significantly higher Family Pillar scores at pre-treatment (M = 3.71,

SD = 0.30) than non-completers (*M* = 3.33, *SD* = 0.45), *t*(17.94) = -2.52, *p* = .022, Cohen's *d* = 0.99. At Session 1, completers reported significant higher Family Pillar scores at Session 1 (*M* = 3.57, *SD* = 0.44) than non-completers (*M* = 3.23, *SD* = 0.46), *t*(35) = -2.34, *p* = .025, Cohen's *d* = 0.76. At the end of the training completers reported significant higher Family Pillar scores at Session 7 (*M* = 3.30, *SD* = 0.59) than non-completers (*M* = 2.73, *SD* = 0.24), *t*(23) = -2.24, *p* = .035, Cohen's *d* = 1.27.

Spiritual pillar. The Spiritual Pillar subscale of the MBS addresses the notion that Latinas are the spiritual leaders of the family and that they are responsible for the family's spiritual growth. Treatment completers reported significant higher Spiritual Pillar scores (*M* = 3.31, *SD* = 0.73) than non-completers (*M* = 2.60, *SD* = 0.88), *t*(27) = -2.39, *p* = .024, Cohen's *d* = 0.88. Treatment completers endorsed more traditional spiritual gender role beliefs than non-completers.

Hypotheses

Hypothesis 1: There will be a decrease in PHQ-9 scores from pre to post-test. The first hypothesis predicted that participants' depressive symptoms would decrease through their participation in the seven-week EDSM depression intervention. Symptoms of depression were measured using the PHQ-9. A paired sample t-test was conducted to compare PHQ-9 scores (*N* = 23) from pre-test to post-test. There was a statistically significant difference between the scores at pre-test (*M* = 11.04, *SD* = 6.50) and post-test (*M* = 4.39, *SD* = 3.49), *t*(22) = 5.76, *p* = .001, Cohen's *d* = 1.27.) Participant's symptoms of depression significantly decreased during their participation in the intervention.

Hypothesis 2: There will be a statistically significant negative rank order correlation for total depression symptoms on the PhQ-9. The second hypothesis predicted that participants' depressive symptoms would decrease through their participation in the seven-week EDSM depression intervention. Kendall's Tau analysis was conducted to examine the correlation between PHQ-9 and time. Alpha level for analyses was set at .05 and the analysis was conducted for each participant. Results for each participant were variable. Findings resulted in a variety of positive and negative correlations and not all were statistically significant. Of the 25 participants in the sample, 9 (36%) had statistically significant negative tau correlations, which suggest there was a reduction in depressive symptoms; see Table 16 for individual results.

Table 16

PHQ-9 Rank Order Correlations

Participant ID	Kendall's Tau	
	Tau-base	*p-value*
2	-0.62	0.05*
3	-0.97	0.01**
5	-0.95	0.04*
7	-0.55	0.12
8	0.48	0.20
9	0.48	0.20
11	-0.55	0.18
16	-0.26	0.42
17	-0.60	0.22
18	-1.00	0.00***
20	-0.55	0.12
21	-0.58	0.24
25	0.55	0.18
27	-0.64	0.04*
28	-0.21	0.70
30	-0.71	0.03*
33	-0.59	0.13
35	-0.74	0.02*
36	0.18	1.00
37	-0.87	0.02*
39	-0.50	0.24
41	*-1	0.00***
46	-0.60	0.13
47	-0.45	0.43
51	0.10	0.88

Note. Significance is set at $*p < .05$, $**p < .01$, $***p < .0001$.

Figure 1 displays a graph of averaged group PHQ-9 scores across the six groups of treatment across the forty-week data collection period. Each group was implemented in a staggered fashion over time with the replication of several A-B phase changes across more than one individual. The dotted lines represent the separation between Phase A (pre-treatment) and Phase B (intervention). Visual analysis shows a decline in PHQ-9 total scores, indicating a negative association between depression scores and course of treatment, which is supported by the statistically significant findings related to hypothesis 1.

Figures 2-7 note the trajectory of PHQ-9 total scores for each participant within each group across the duration of the treatment. The number of depressive events (DE) that each participant experienced throughout the treatment is noted along with their classification of clinically depressed (CD; 0 = no, 1 = yes) at pre-post treatment.

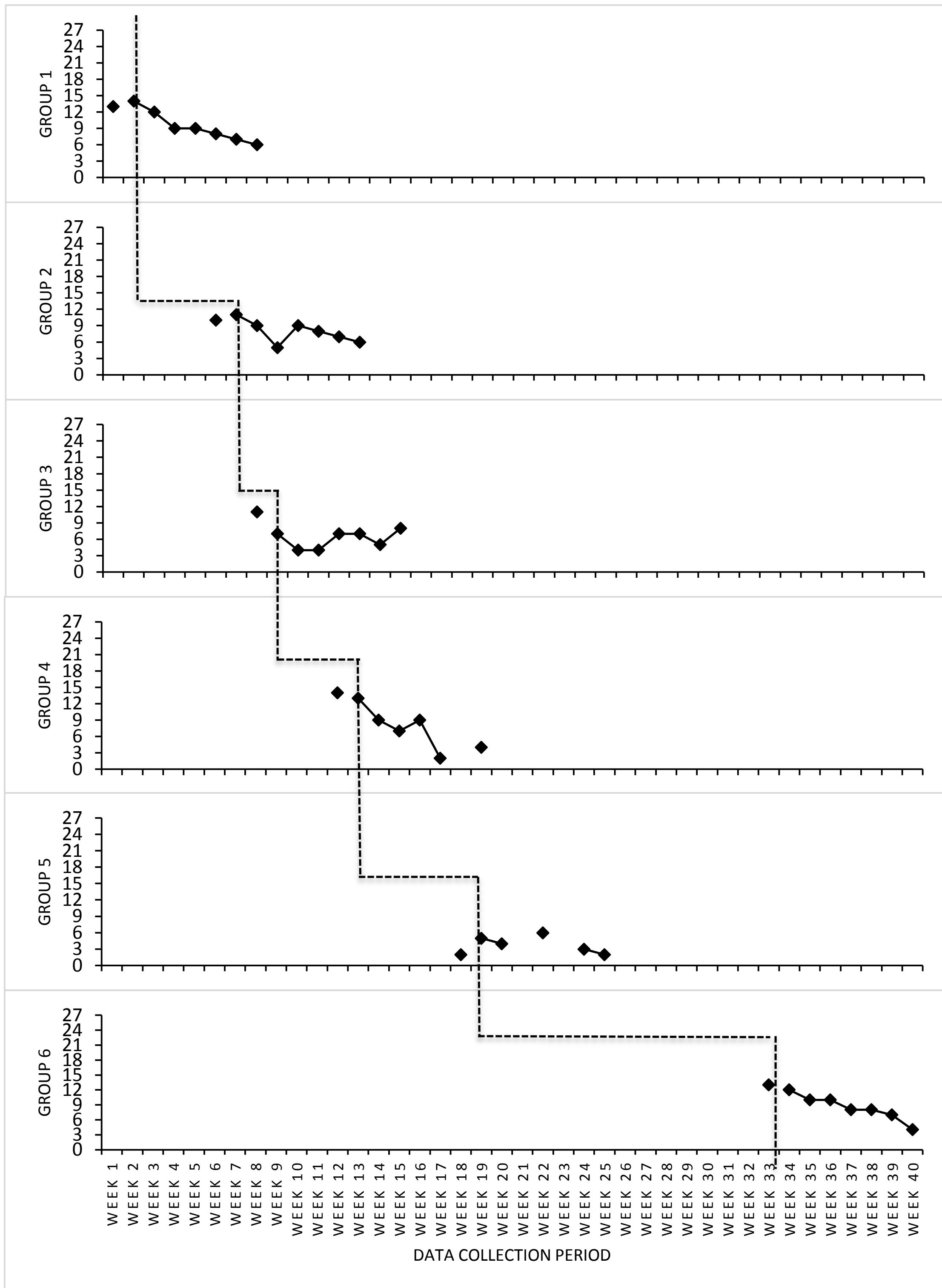

Figure 1. PHQ-9 averaged total scores by group (n = 6).

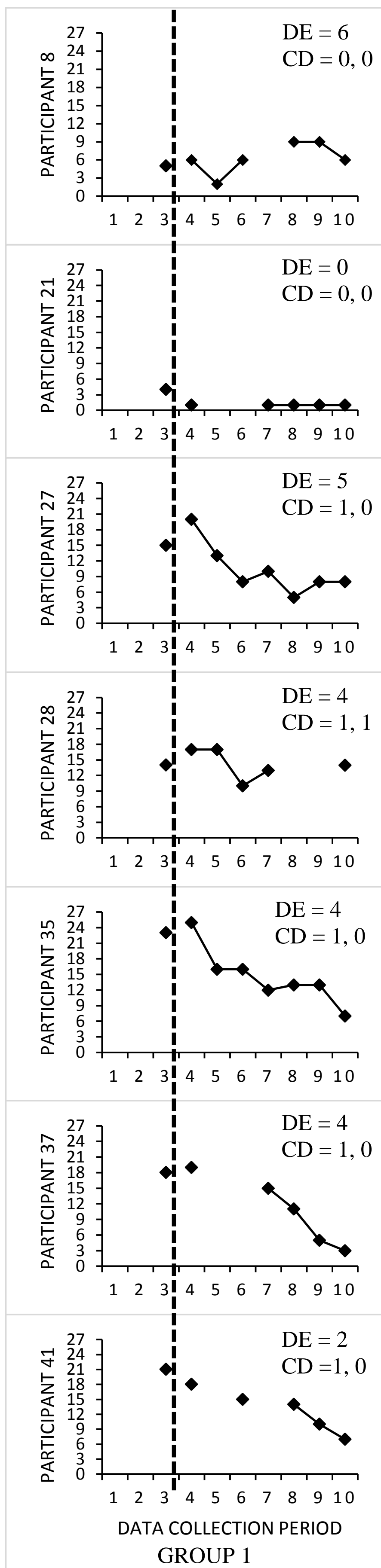

Figure 2. Group 1 individual PHQ-9 total scores, number of depressive events (DE), and clinical depression (CD).

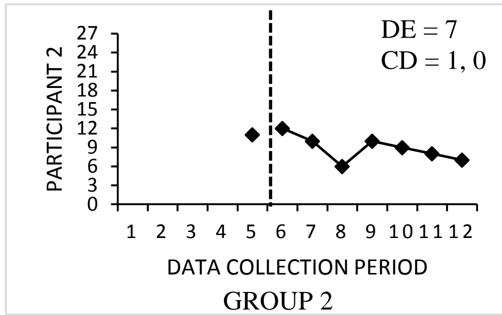

Figure 3. Group 2 individual PHQ-9 total scores, number of depressive events (DE), and clinical depression (CD).

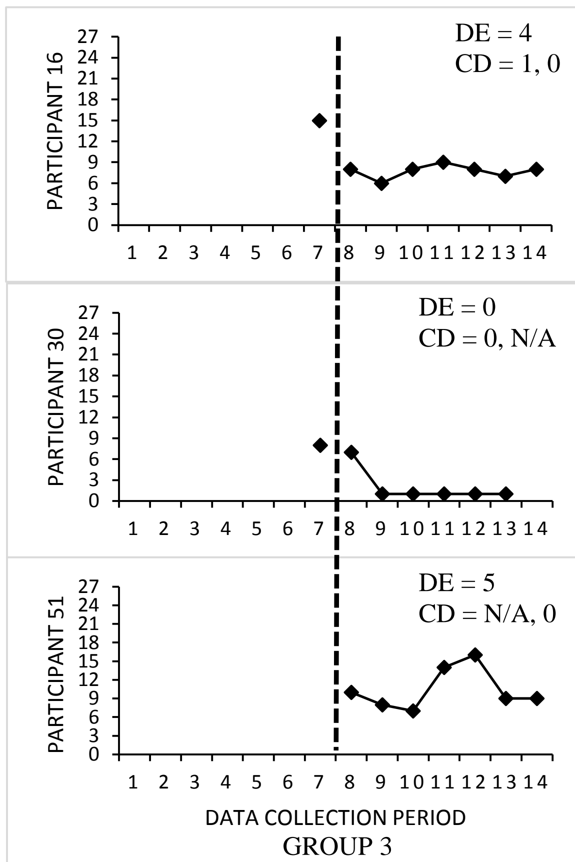

Figure 4. Group 3 individual PHQ-9 total scores, number of depressive events (DE), and clinical depression (CD).

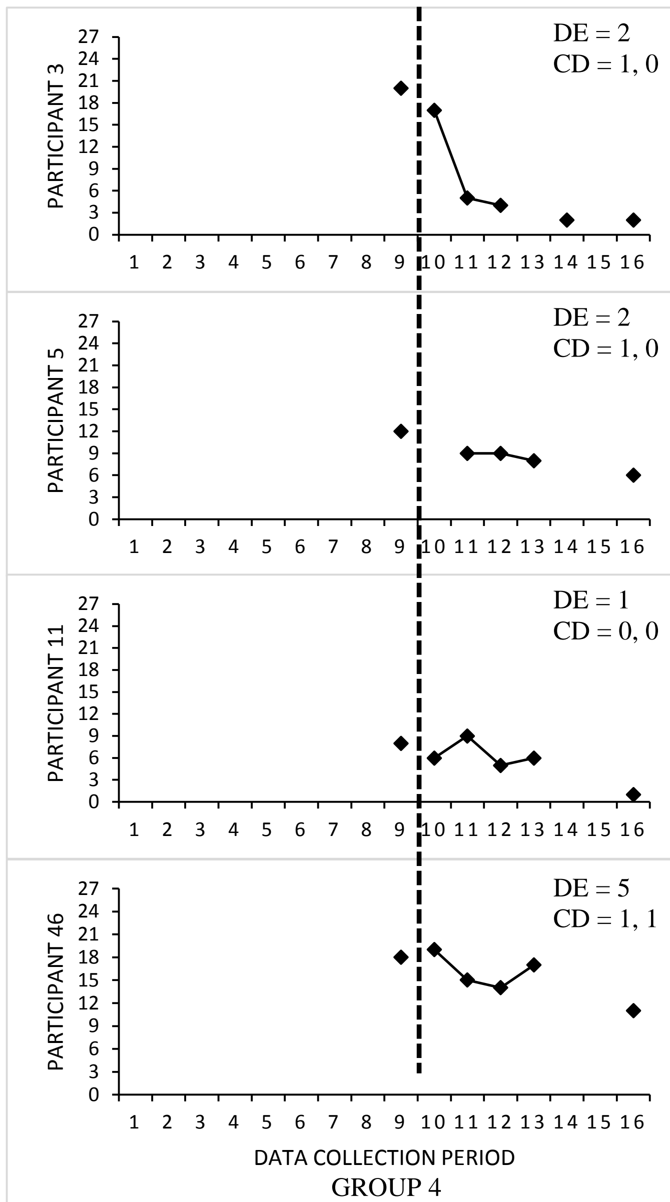

Figure 5. Group 4 individual PHQ-9 total scores, number of depressive symptoms (DE), and clinical depression (CD).

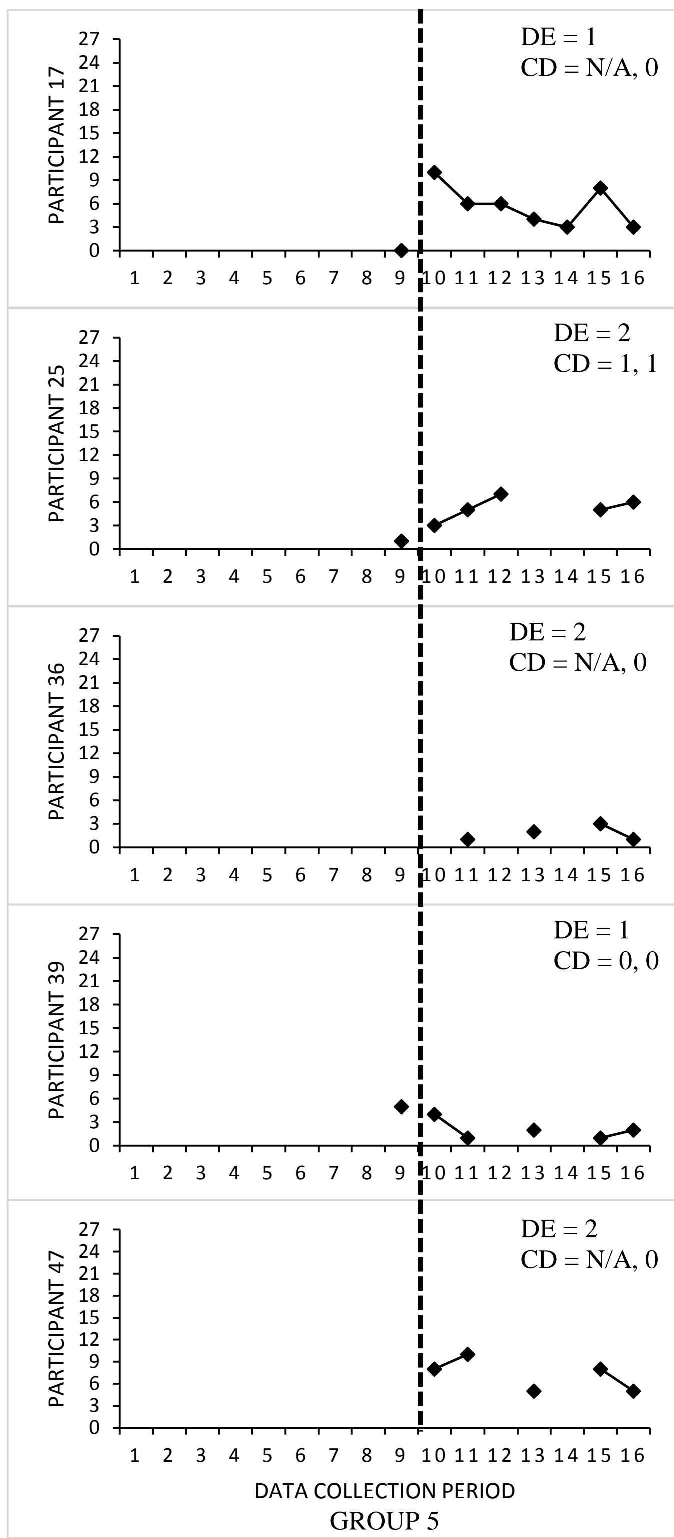

Figure 6. Group 5 individual PHQ-9 total scores, number of depressive events (DE), and clinical depression (CD).

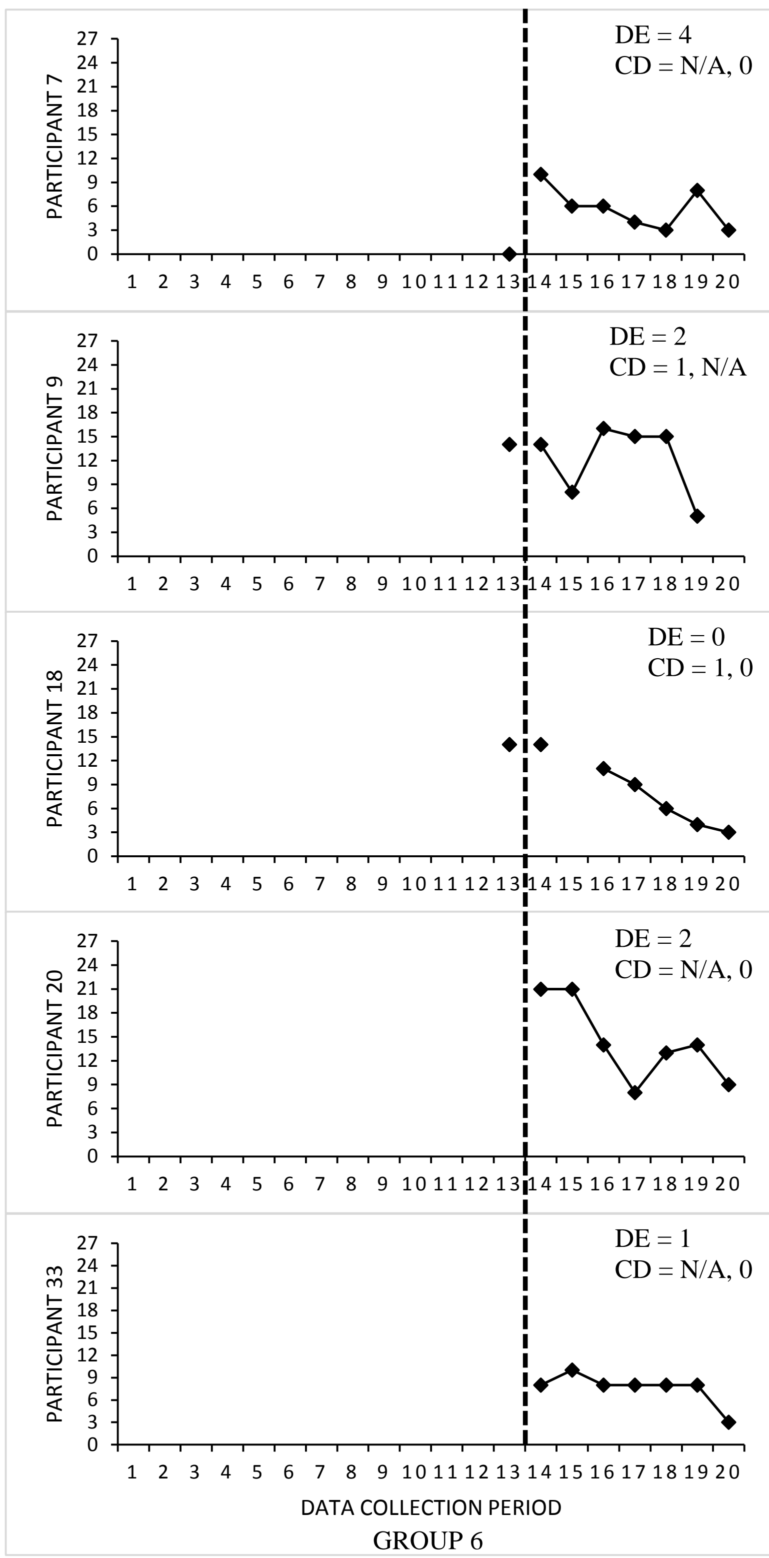

Figure 7. Group 6 individual PHQ-9 total scores, number of depressive symptoms (DE), and clinical depression (CD).

Hypothesis 3: There will be a decrease in MBS total scores from pre to post-test. A paired sample t-test was conducted to compare total gender role beliefs scores (N = 17) at pre-test and post-test. Results indicate that there was a statistically significant difference between the scores at pre-test (M = 2.74, SD = .39) and post-test (M = 2.54, SD = .63), $t(16)$ = 2.22, p = .04, Cohen's d = 0.38. Cohen's statistic suggests a small effect size.

Hypothesis 4: There will be no change in Family Pillar subscale scores from pre to post-test. A paired sample t-test was conducted to compare Family Pillar subscale scores (N = 15) for pre-test and post-test. There was no statistically significant difference between pre-test scores (M = 3.52, SD = .46) and post-test scores (M = 3.27, SD = .64), $t(14)$ = 1.13, p = .28, Cohen's d = 0.44. Findings indicate that family pillar beliefs did not change during the course of the intervention.

Hypothesis 5: There will be a decrease in Virtuous and Chaste subscale scores from pre to post-test. A paired sample t-test was conducted to compare Virtuous and Chaste subscale scores (N = 17) at pre-test and post-test. There was a statistically significant difference between the scores for pre-test (M = 3.4, SD = .57) and post-test (M = 2.94, SD = .78), $t(16)$ = 3.76, p = .002, Cohen's d = 0.67. Findings indicate that Marianismo beliefs regarding being virtuous and chase were lower during the course of the intervention.

Hypothesis 6: There will be a decrease in Subordinate to Others subscale scores from pre to post-test. A paired sample t-test was conducted to compare Subordinate to Others subscale scores (N = 17) for pre-test and post-test. There was no

statistically significant difference between the scores at pre-test (M = 1.87, SD = .53) and post-test (M = 1.94, SD = .79), $t(16)$ = -.65, p = .52, Cohen's d = -0.10. Findings indicate that Marianismo beliefs regarding being subordinate to others did not change during the course of the intervention.

Hypothesis 7: There will be a decrease in Silencing the Self subscale scores from pre to post-test. A paired sample t-test was conducted to compare Silencing the Self subscale scores (N = 17) for pre-test and post-test. There was no statistically significant difference between the scores at pre-test (M = 1.92, SD = .49) and post-test (M = 2.06, SD = .74), $t(16)$ = -.90, p = .38, Cohen's d = -0.22. Findings indicate that Marianismo beliefs regarding silencing the self did not change during the course of the intervention.

Hypothesis 8: There will be no change in Spiritual Pillar subscale scores from pre to post-test. A paired sample t-test was conducted to compare Spiritual Pillar subscale scores (N = 17) for pre-test and post-test. There was a statistically significant difference between the scores at pre-test (M = 3.20, SD = .76) and post-test (M = 2.59, SD = .90), $t(16)$ = 4.15, p = .001, Cohen's d = 0.73. Contrary to expectations, findings indicate that Marianismo beliefs regarding the spirituality pillar changed during the course of the intervention. Specifically, these results imply that Spiritual Pillar scores decreased during treatment.

Post-hoc Analyses

Post-hoc analysis was conducted to examine participants who were clinically depressed at the beginning of the intervention (e.g., pre-treatment and first session, prior

to the intervention) and determine if they continued to be depressed at the end of the intervention. Chi-square analysis was used to determine statistical significance. Pre-test data was measured individually at pre-treatment and Session 1 and each was compared to Session 7. The two pre-treatment comparisons were conducted to account for attrition, common among Latinas engaging in mental health services (Barrett et al., 2008; Kouyoumdjian, Zamboanga, & Hansen, 2003; Miranda et al., 1996). For example, participants who provided data may have not attended the first session, while participants who attended Session 1 may not have provided pre-treatment data. Both data points, pre-treatment and Session 1 were analyzed as pre-treatment data.

Nine participants who were clinically depressed at pre-treatment were no longer clinically depressed at the end of treatment, X^2 (1, N = 18) = 1.43, p = .23. Two participants who were Clinically Depressed (CD) at pre-treatment continued to be CD at the end of treatment. The χ^2 test was not statistically significant and likely due to a small sample size.

Comparisons between the first session (S1), prior to treatment and the end of treatment (S7) yielded the following results (see Table 17). Participants who were not CD at S1 did not become CD at S7. Eight participants who were clinically depressed at S1 were no longer clinically depressed at S7, X^2 (1, N = 24) = 3.06, p =.08. Two participants who were CD at S1 continued their clinically depressed state at S7.

Table 17

Post Hoc Analysis, Clinically Depressed at Pre-Post Treatment

	Pre-Post Treatment (Pre-treatment vs. S7)		Pre-Post treatment (S1 vs. S7)	
	Pre	Post	Pre	Post
Clinically depressed	11	2	10	2
Non-depressed	7	7	14	14

Note. S1 = Session 1, pre-treatment; S7 = Session 7, post-treatment

CHAPTER IV

CONCLUSION

The primary purpose of this study was to evaluate the effectiveness of a seven-week Promotora-led modified version of EDSM. Analysis of the group's overall scores revealed a statistically significant reduction of depressive symptomatology pre and post intervention. However, analysis of scores at the individual level (e.g., participant serving as her own control) only revealed a statistically significant reduction of depressive symptoms for 36% of participants. As such, further interpretation of findings is necessary to explore the extent of the intervention's effectiveness.

This chapter will 1) discuss interpretations of key findings, 2) discuss and integrate study results with existing literature concerning culturally-grounded interventions for Latinas and unique aspects of gender role beliefs, 3) discuss limitations of the study, and 4) provide clinical implications and recommendations for future research.

Interpretation of Key Findings

Consistent with Lara et al.'s (2003a and 2003b) findings, statistically significant improvements at the group level were found for the present EDSM intervention. The present study attempted to go further by examining individual cases and identified that only 36% of participants achieved statistically significant reduction in symptoms. Actively engaged participants (i.e., completers) reported statistically significant higher depression scores than partially engaged individuals (i.e. non-completers). Although we

cannot explain specifically why those who were more depressed completed the intervention, we can speculate that because they were more depressed, they were more vested to stay in the training (Iterian, Allen, Gara, & Escobar, 2008; Organista, Muñoz, & González, 1994). Additionally, participants reported an average of 2.72 (range 0-7) depressive events (e.g., fighting with a spouse, receiving bad news, etc.) occurring over the course of the 7-week intervention. It is possible that these depressive events interfered with overall intervention response.

It was predicted that as participants went through the course, they could experience a shift in their traditional gender role beliefs, leading to less traditional beliefs in certain domains. As expected, scores on pre and post analysis of the MBS as a whole demonstrated lower scores at the end of treatment. Virtuous and Chaste Pillar also demonstrated lower scores at the end of treatment, indicating less traditional beliefs within this domain. This finding could be attributed to Session 4, where substantial focus is placed on the topics of female sexuality, virginity, adopting values and beliefs imposed by religion (i.e., Catholicism), and the media's impact on beliefs and behaviors (e.g., *telenovelas*/soap operas).

Social models can serve as transmitters of values, knowledge, cognitive skills, and new styles of behavior (Bandura, 2004). Within the media, representative models can influence people's social constructions of reality based on what they see, hear, and read (Bandura, 2004). Wilkin et al. (2007) conducted a study with Latina and Latino men residing in the US and examined the effects of a telenovela breast cancer storyline on changing knowledge about breast cancer screenings Findings indicated that accurate

health information in entertainment programming (i.e., telenovelas) increased knowledge and behavioral intent among Latina/o audiences in the U.S., particularly if the viewer identified with the characters. Telenovelas can serve as transmitters of cultural and health messages; thus, it would not be surprising that gender norm expectations would be adapted through vicarious viewing. As such, within the EDSM training, participants were encouraged to reflect on how beliefs about gender roles are embedded throughout life stages (e.g., pregnancy and adult life), including their own. During this session, differences between gender and sex were explored and participants dispelled myths regarding female sexuality.

There were several unexpected findings within the subscales of the MBS. First, Silencing the Self to Maintain Harmony (SSMH) and Subordinate to Others (SO) subscales did not change significantly in response to treatment. This finding was unexpected as the modified EDSM discussed how women in Latino culture tend to be oppressed within a patriarchal society. Examples of this are staying in the home to take care of their children vs. pursuing a professional career (*ser profesionista*) or seeking careers that are "*servicial*" (e.g., secretary, nurse, teacher). A possible explanation for the lack of statistical significance within SSMH and SO scores could be attributed to participants holding less traditional beliefs within these domains at the start of the intervention. For example, mean scores of 2.5 or higher indicate an adherence to traditional gender role beliefs. On the SSMH and the SO subscales, pre-treatment mean scores were 1.92 and 1.87, respectively. These findings indicate that participants did not

hold traditional beliefs within these two domains because their perspectives were already nontraditional prior to the intervention.

A decrease in Spiritual Pillar (SP) subscale scores at the end of treatment was an unexpected finding. Religiosity and spirituality are tightly interwoven within the Latino culture (García-Vázquez & Marin, 2014). The belief that women are responsible for the family's spiritual religious education and growth (Castillo et al., 2010; Piña-Watson et al., 2014) was not expected to change as a result of their participation in the EDSM intervention. A study examining the MBS and Spiritual Pillar among Guatemalan women (de Gamalero et al., 2014) found that older generations of women, aged 50 and older, held solid beliefs that they should be the spiritual pillar of the family. The authors contended it is possible that this belief is diminished across younger generations (participants were about 10 years younger than those in the present study). A possible explanation for the decrease in Spiritual Pillar scores could be attributed to age and should be examined in depth in future research.

The decrease in SP scores could also be attributed to content from the EDSM curriculum where substantial focus is placed on exploring gender roles, discussing how sociocultural beliefs are developed, and being responsible for our own actions and problem solving. During Session 1, the training begins to deconstruct myths about the role of Latina women in the household. For example, they are presented with statements such as, "If someone in my family has problems, it is my responsibility as a woman and mother to resolve those problems," "The principal responsibility of married women is attending to their husbands," and "Mothers are responsible for the education of their

children." As a group, participants discuss the degree to which they agree/disagree with the aforementioned statements and explore how these beliefs are developed. During Session 4, participants engage in an in-depth discussion about gender role beliefs and how those beliefs developed. For example, gender roles are explored through pregnancy, childbirth, childhood, adolescence, and adult life. In addition, differences between gender and sex and gender expectations are explored. In Session 5, religious institutions, their cultural messages, and their potential impact on mental health are explored. Throughout the training, spirituality and religious beliefs were discussed as participants found these concepts to be relevant to the session content discussion and activities.

An adherence to traditional gender role beliefs in the MBS and subscales are measured by a mean score of 2.5 or higher. Participant mean scores decreased from 3.2 to 2.59 at post-test. Although the decrease in scores was statistically significant, participant mean scores were higher than the suggested 2.5 cut off, indicating that their beliefs were less traditional than at the start of the intervention, yet they continued to hold traditional beliefs in this domain. Scholars at the forefront of examining marianismo and the pillars that comprise marianismo among Latinas (Castillo et al., 2010; Perez, 2011; Reyes, 2013) posit that marianismo is a multidimensional construct, where their adherence to various domains may differ. For example, a participant may be more traditional in Family Pillar vs. Virtuous and Chaste.

Limitations of the Study

The small sample size stands at the forefront of the limitations to the study. Although the investigator and the Promotoras actively recruited community participants

through local organizational partnerships, starting a new program in a community unfamiliar to mental health services was challenging. Issues of stigma and trust may have contributed to the low number of individuals consenting to participate. Other factors contributing to the small sample size were a high attrition rate (50%) and difficulty starting the groups. Group 2 and Group 3 were difficult to establish although several efforts were made to accommodate the population (e.g., hosting a group in the evenings or on a Saturday). Once the third group had been conducted, others in the community learned of the program and groups began to form organically. By the fifth and sixth group, there was limited recruitment effort on behalf of the investigator. In fact, Promotoras approached the investigator asking if Group 5 and Group 6 could be formed as members of their community had requested them. In these groups, participants from previous groups volunteered to provide childcare to the aforementioned groups.

A second notable limitation was data collection and instrumentation. Ideally, analysis at the individual level would have followed SCR design, which requires the collection of a minimum of three baseline points for Tau-U data analysis. Due to the recruitment challenges, only one baseline data point across all groups was achievable. A second component of SCR research design involves repeated measurement. Due to inconsistent attendance and/or participant mistrust, repeated measurement of the variables examined was also unachievable and this resulted in missing data. Thus, SCR data analysis was not conducted in its true form. Factors leading to this limitation will be explored in the section addressing CPs as novices to research.

Missing data compromised the design of subsequent analysis. CPs and CHWs may have been unfamiliar with repeated weekly measurement and obtaining baseline measures prior to the start of the intervention. This may have impacted data collection and study results. Misinformation may have also contributed to low survey completion. For example, some participants falsely believed that their disclosure of depression symptoms would be reported to Child Protective Services (CPS) and the removal of their children ("*quitarme los niños).* Others were concerned about protection or deportation due to undocumented status. Maternal depression is associated with abusive parenting and negative maternal behavior, so participants were less likely to report these symptoms (Ostler, 2015). Among non-citizen immigrant families, previous negative experiences with repressive government agencies in their country of origin could result in misconceptions about CPS and the responsibilities of CPS workers (Kriz et al., 2012). Among low-income immigrant communities (particularly Latin American immigrants), the fear of CPS can translate to a fear of deportation and other legal consequences. Therefore, immigrants may avoid contact with mandatory reporters, such as health care professionals (Vericker, Kuehn, & Capps, 2007), including mental health providers. Consequently, individuals may then engage in impression management in order to maintain the family unity (Kriz et al., 2012). The aforementioned, coupled with fear and misinformation, may have adversely affected participant survey completion and resulted in missing data. Groups 5 and 6 exhibited some misconceptions about completing the PHQ-9 and the Promotoras and PIs relationship with government agencies. The PI clarified her role within the study and told participants that she had no relation with CPS,

unless state mandated limitations to confidentiality were in effect (i.e., suspected or stated abuse of a child).

Promotoras in this study donated their time and service to the community. Although the Promotoras were trained on the administration of the PHQ-9, some expressed that they did not feel equipped to answer questions and would defer to the PI during administration. CHWs are increasingly incorporated as part of research teams (Hohl et al., 2016; Nebeker et al., 2015; Viswanathan et al., 2004) and are beginning to adopt *Promotora*-researcher roles (St John et al., 2013). CHWs continuously report a need for professional development training, including research roles (Catalani et al., 2009). To address research training needs of Promotoras in this study, while maintaining rapport built with CPs, the PI provided the rationale for repeated measurement and expressed the value of research for developing interventions that could meet the needs of the community. In order to educate CPs on the importance of community research, the researcher used a widely recognized cultural phrase among Mexican immigrant populations, "*En los Estados Unidos, el papelito habla*" (loosely translated in English, "In the United States, the paper speaks, so nothing else is valid.") (Sierra, 2013), to mean that without documentation (i.e., data) nothing can happen (e.g., legal). Research was required so interventions that address physical and mental health needs in their community could be developed. Trust between the CPs, CHWs, and PI was vital to data collection.

Clinical Implications and Recommendations for Future Research

In light of current findings, several clinical implications and recommendations for future research are recommended when working with Latinas who are experiencing or are at risk of developing symptoms of depression. First, when developing interventions for Latinas with symptoms of or at risk of depression, the interventions should be culturally grounded. Although there is evidence to support that other treatments are effective when working with Latinas, this intervention was readily received by participants due to the cultural groundedness of the intervention. Many other interventions, including CBT and BA are culturally adapted, or culturally modified to meet the needs of Latinos, indicating a top-down design of interventions, which implies that interventions are developed and integrate culture as an afterthought. Miranda et al., (2005) conducted a literature review on psychosocial interventions for ethnic minorities, including Latinos. In the review, this author noted at least twelve different terms to refer to treatment being accommodated to include ethnic minority values and culture. These terms include: culturally modified, culturally adapted, culturally congruent, cultural variation, culturally responsive, cultural leverage, culturally grounded, culturally informed, culturally tailored, surface structure adaptations, deep structure adaptations, and ethno political approaches. When developing interventions for Latinas, it is important to think about culture first and how evidence based theories can be integrated. This might lead to better receptivity of mental health services by these underserved groups. Clinicians might want to consider the use of the EDSM as a treatment due to its unique development, a bottom up approach that is culturally grounded where Lara et al.

(2004) conducted focus groups on how Latinas experience depression. In this study, the training was well received by participants, which is reflected by the organic growth of the intervention groups.

Clinicians should consider early assessment of gender role beliefs among the Latina clients/patients they serve. Latinas are heterogeneous and their marianismo beliefs are multidimensional. We should consider that although they may overall hold traditional gender role beliefs, their perceptions within specific domains of marianismo may differ (e.g., Family vs. Spiritual Pillar beliefs).

The EDSM intervention merits further evaluation to assess its effectiveness in reducing depressive symptoms among Latinas and its impact on Latina gender role beliefs. Its continued rigorous assessment has the potential to determine this intervention as an evidence-based, culturally grounded and appropriate treatment for Latinas with depression that clinicians and CHWs/Promotores can use as a treatment or preventive modality. In the US, the curriculum has been accepted and used widely throughout San Diego, CA and El Paso, TX; yet to date and to this author's knowledge, no peer-reviewed publications except Lara et al.'s (2003a and 2003b) study report on its effectiveness. This study adds to the literature and provides some support that the "*¿Es Difícil Ser Mujer?*" intervention was associated with reductions in depressive symptoms among participants as a group and for a select few, at the individual level.

Recommendations for future research are proposed: 1) provide education to community participants and CHWs/Promotoras on the value and purpose of research, 2) use mobile health (mHealth) technology for data collection, 3) further examine the

Marianismo Beliefs Scale and its association to depression among Latinas, and finally, compare the EDSM curriculum to EBTs such as CBT and BA.

First, Latina populations are best served by researchers and treatment providers that can respectfully address and circumvent traditional barriers to mental health (e.g., gender role beliefs, stigma, mistrust in completing paperwork). One way to address this is to provide education to community participants and CHWs/Promotoras on the value and purpose of research and repeated measurement. One such training is the Building Research Integrity and Capacity (BRIC) (Nebeker & López-Arenas, 2016; Nebeker, Kalichman, López-Arenas, & Booen, 2015). By understanding the purpose and nature of research, participants may be more inclined to engage in treatment and complete surveys in full, allowing for better assessment of the EDSM and other culturally grounded interventions.

Second, the use of mobile health (mHealth) technology (e.g., smartphones, iPads) for data collection may help in achieving more accurate results and better patient care. For example, mHealth technologies can be a tool to assist CHWs (and providers) in patient monitoring, education and awareness, appointment and follow-up reminders, and data collection/submission (Braun et al., 2013; Källander et al., 2013); thus potentially reducing participant attrition and missing data. For a more precise evaluation of the EDSM intervention, attendance and survey completion is key. This author recommends sending reminder text alerts and completing surveys “online,” which can be achieved by using software (i.e., Qualtrics). These surveys can be completed on a smartphone/tablet

device “offline” in the case that Internet is not available. Participants can be prompted to complete items, which might not be achievable with traditional paper/pen surveys.

Third, findings on the influence of EDSM on Latina gender role beliefs are intriguing. Further examination of the MBS and its association with depression is merited. Understanding the specific multidimensional pillars of the MBS and its association with depression can help clinicians and researchers better understand the client and provide better treatment. A qualitative study examining the impact of EDSM on gender role beliefs is suggested.

Lastly, and most importantly, the EDSM curriculum should be tested and compared to EBTs such as CBT and BA. CBT and BA treatments have been adapted/modified and developed from a top-down approach and it would be noteworthy to compare treatments to the culturally grounded EDSM intervention, which was developed from a bottom-up approach, starting with the culture while integrating evidence based theory.

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APPENDIX A

Instrucciones: Por favor conteste todas las preguntas lo mejor que pueda y recuerde, toda información permanecerá confidencial:

Fecha de Nacimiento: ____/____/____ **¿En qué idioma prefiere hablar?** _____ Ingles _____ Español

¿En donde nació? ________________ **¿Cuánto tiempo lleva viviendo en los E.U.?** _____ años/meses

¿Quién en su familia fue el primer/la primera en venir a los Estados Unidos?
☐ Yo
☐ Mis papas—(por lo menos uno de ellos)
☐ Mis abuelos
☐ Mis bisabuelos

Estado Civil:
☐ Soltera (nunca casada) ☐ Casada ☐ Separada ☐ Divorciada ☐ Viviendo con una pareja ☐ Viuda

Raza/Etnicidad:
☐ Mexicana/México-Americana/Chicana
☐ Centro Americana (ej. Salvadoreña, Guatemalteca)
☐ Sur Americana (ej. Boliviana, Peruana)
☐ Caribeña (ej. Cubana, Dominicana, Puerto Riqueña)
☐ Otro (por favor especifique, ej. mixta/birracial—Mexicana y Boliviana) ________________________

Ocupación: ☐ Tiempo completo ☐ Medio tiempo ☐ Ama de Casa ☐ Estudiante ☐ Pensionada
☐ Desempleada ☐ Otro ____________________

¿Cuál es el último grado de estudio que usted ha terminado? (ej. sexto grado) _______________

Ingreso Familiar: aproximadamente $______________ ☐ semanal ☐ quincena ☐ mes ☐ año

Religión: ____________________ ¿Con que frecuencia, practica usted su religión? (ej. voy a misa cada semana, no practico)
____

Si necesitara servicios de salud mental, yo me sentiría cómoda utilizando los servicios de salud mental (ej. psicoterapia, grupos de apoyo, medicamento, etc.).
☐ Si, me siento cómoda. ¿Por qué? ____
☐ No, no me siento cómoda. ¿Por qué? ____

¿Si esta recibiendo servicios de salud mental, qué tipo de servicio(s) está usted recibiendo?
____

¿Usted ha sido diagnosticada con alguna enfermedad (ej. diabetes, hipertensión, etc.)? ☐ Sí ☐ No
¿Qué enfermedad(es) le han diagnosticado? ______________________________

En cuestión de salud, yo creo que me cuido de manera regular y adecuada.

☐	☐	☐	☐	☐
Nunca	No mucho	Un poco	Bastante	Siempre
1	2	3	4	5

¿De qué manera? (ej. comer saludablemente, ir al doctor) ______________________________

¿Qué es lo que la trajo a este curso? ____
____

2 – 02.29.12

Fecha __________ Iniciales __________

PRIME-MD Patient Health Questionnaire – PHQ-9

¿Durante la última semana, con que frecuencia le han molestado los siguientes problemas? **(Circule un número del 0 al 3 para indicar su respuesta)**	**Nunca**	**Varios Días**	**La Mayoría de los Días**	**Casi Todos los Días**
1. Tengo poco interés o placer en hacer las cosas	0	1	2	3
2. Me siento decaída, desanimada, deprimida, o sin esperanza	0	1	2	3
3. Tengo problemas para dormir o mantenerme dormida, o duermo demasiado	0	1	2	3
4. Me siento cansada o tengo poca energía	0	1	2	3
5. Tengo poco apetito o como en exceso	0	1	2	3
6. Me siento con falta de amor propio, que soy un fracaso, o que soy una decepción para mi familia o conmigo misma	0	1	2	3
7. Tengo dificultad para concentrarme en cosas cotidianas por ejemplo, leer, ver televisión, conversar, manejar, etc.	0	1	2	3
8. Me muevo o hablo tan lentamente que otra gente se podría dar cuenta- o de lo contrario, estoy tan agitada o inquieta que me muevo mucho más de lo acostumbrado	0	1	2	3
9. He tenido pensamientos de lastimarme o que sería mejor estar muerta*	0	1	2	3

**** Si tiene pensamientos de lastimarse o de que sería mejor estar muerta, por favor hable con su médico, vaya a una sala de emergencia, o llame al 911.***

10. Si usted se identificó con cualquiera de los problemas mencionados en este cuestionario, ¿qué tan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

Nada en Absoluto ☐ **Algo Difícil** ☐ **Muy Difícil** ☐ **Extremadamente Difícil** ☐

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3 – 02.29.12

Instrucciones: Las declaraciones abajo representan algunas de las diversas expectativas para Latinas. Para cada declaración, por favor marque la respuesta que describe mejor lo que usted cree más bien qué lo que le enseñaron o lo que usted practica realmente.

Una Latina…	**Fuertemente No De Acuerdo 1**	**No De Acuerdo 2**	**De Acuerdo 3**	**Fuerte-mente De Acuerdo 4**
1. Debería de ser una fuente de fortaleza para la familia.	1	2	3	4
2. Es considerada la fuente principal de fuerza para su familia.	1	2	3	4
3. Madre debería de mantener a su familia unida.	1	2	3	4
4. Debería de enseñarles a sus niños ser leales a su familia.	1	2	3	4
5. Debería de hacer cosas que hagan feliz a mi familia.	1	2	3	4
6. Debería (hubiera) permanecer/permanecido virgen hasta el matrimonio.	1	2	3	4
7. Debe de esperar hasta después del matrimonio para tener hijos.	1	2	3	4
8. Debería de ser pura.	1	2	3	4
9. Debería de adoptar los valores inculcados por su religión.	1	2	3	4
10. Debería serle fiel a mi pareja.	1	2	3	4
11. Debería satisfacer las necesidades sexuales de mi pareja sin quejarme.	1	2	3	4
12. No debería alzar su voz contra los hombres.	1	2	3	4
13. Debería respetar las opiniones de los hombres aunque no esté de acuerdo.	1	2	3	4
14. Debe de evitar decirles "no" a la gente.	1	2	3	4
15. Debería hacer cualquier cosa que le pida un hombre de la familia.	1	2	3	4
16. No debe de hablar de métodos anticonceptivos.	1	2	3	4
17. No debe expresar sus necesidades a su pareja.	1	2	3	4
18. Debe de sentirse culpable por decirle a la gente sus necesidades.	1	2	3	4
19. No debe de hablar del sexo.	1	2	3	4
20. Debe perdonar en todos aspectos.	1	2	3	4
21. Siempre debería estar de acuerdo con las decisiones de los hombres.	1	2	3	4
22. Debería de ser la líder espiritual de la familia.	1	2	3	4
23. Es responsable de llevar a su familia a servicios religiosos.	1	2	3	4
24. Es responsable del crecimiento espiritual de su familia.	1	2	3	4

5 – 02.29.12

APPENDIX B

Instrucciones: Por favor conteste todas las preguntas lo mejor que pueda y recuerde, toda información permanecerá confidencial:

PRIME-MD Patient Health Questionnaire – PHQ-9

¿Durante la última semana, con que frecuencia le han molestado los siguientes problemas? **(Utilice "✓" para indicar su respuesta)**	**Nunca**	**Varios Días**	**Más de la Mitad de los Días**	**Casi Todos los Días**
1. Tengo poco interés o placer en hacer las cosas	0	1	2	3
2. Me siento desanimada, deprimida, o sin esperanza	0	1	2	3
3. Tengo problemas en dormirme o mantenerme dormida, o en dormir demasiado	0	1	2	3
4. Me siento cansada o tengo poca energía	0	1	2	3
5. Tengo poco apetito o como en exceso	0	1	2	3
6. Me siento con falta de amor propio, que soy un fracaso, o que me decepcionare a mi misma o a mi familia	0	1	2	3
7. Tengo dificultad para concentrarme en cosas tales como leer el periódico o mirar la televisión	0	1	2	3
8. Me muevo o hablo tan lentamente que otra gente se podría dar cuenta- o de lo contrario, estoy tan agitada o inquieta que me muevo mucho mas de lo acostumbrado	0	1	2	3
9. Se me han ocurrido pensamientos de que seria mejor estar muerta o que me haría daño de alguna manera*	0	1	2	3

SAMPLE 1

**** Si tiene pensamientos de que es mejor estar muerto/a o hacerse daño de alguna manera, favor de hablar con su medico, ir a una sala de emergencia, o llamar al 911.***

10. Si usted se identificó con cualquiera de los problemas mencionados en este cuestionario, ¿qué tan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

Nada en Absoluto	**Algo Difícil**	**Muy Difícil**	**Extremadamente Difícil**
☐	☐	☐	☐

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1

PRIME-MD Patient Health Questionnaire – PHQ-9

Instrucciones: Por favor conteste todas las preguntas lo mejor que pueda y recuerde, toda información permanecerá confidencial.

¿Durante la ultima semana, con que frequencia le han molestado los siguientes problemas? (Utilice "✓" para indicar su respuesta)	**Nunca**	**Varios Días**	**La Mayoría de los Días**	**Casi Todos los Días**
1. Tengo poco interés o placer en hacer las cosas	0	1	2	3
2. Me siento desanimada, deprimida, o sin esperanza	0	1	2	3
3. Tengo problemas en dormir o mantenerme dormida, o duermo demasiado	0	1	2	3
4. Me siento cansada o tengo poca energía	0	1	2	3
5. Tengo poco apetito o como en exceso	0	1	2	3
6. Me siento mal conmigo misma, o que soy un fracaso, o que soy una decepción a mi misma o a mi familia	0	1	2	3
7. Tengo dificultad para concentrarme en cosas tales como leer el periódico o mirar la televisión	0	1	2	3
8. Me muevo o hablo tan lentamente que otra gente se podría dar cuenta- o de lo contrario, estoy tan agitada o inquieta que me muevo mucho mas de lo acostumbrado	0	1	2	3
9. He pensado que seria mejor estar muerta o de dañarme a mi misma de alguna manera*	0	1	2	3

SAMPLE 2

Si tiene pensamientos de que seria mejor estar muerta o de hacerse daño de alguna manera, por favor hable con su medico, vaya a una sala de emergencia, o llame al 911.

10. Si usted se identificó con cualquiera de los problemas mencionados en este cuestionario, ¿qué tan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

Nada en Absoluto	**Algo Difícil**	**Muy Difícil**	**Extremadamente Difícil**
☐	☐	☐	☐

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ALA – 02.20.11

Cuestionario de Salud del Paciente

(PRIME-MD Patient Health Questionnaire – PHQ-9)

Durante las últimas 2 semanas, con que frecuencia le han molestado los siguientes problemas? (Utilice "✔" para indicar su respuesta)	**Nunca**	**Varios Días**	**Más de la Mitad de los Días**	**Casi Todos los Días**
1. Tener poco interés o placer en hacer las cosas	0	1	2	3
2. Sentirse desanimado/a, deprimido/a, o sin esperanza	0	1	2	3
3. Con problemas en dormirse o mantenerse dormido/a, o en dormir demasiado	0	1	2	3
4. Sentirse cansado/a o tener poca energía	0	1	2	3
5. Tener poco apetito o comer en exceso	0	1	2	3
6. Sentir falta de amor propio - o que sea un fracaso o que se decepcionará a si mismo/a o a su familia	0	1	2	3
7. Tener dificultad para concentrarse en cosas tales como leer el periódico o mirar la televisión	0	1	2	3
8. Se mueve o habla tan lentamente que otra gente se podría dar cuenta - o de lo contrario, está tan agitada/o o inquieto/a que se mueve mucho mas de lo acostumbrado	0	1	2	3
9. Se le han ocurrido pensamientos de que seria mejor estar muerto/a o de que haría daño de alguna manera*	0	1	2	3
Para completarse solo por un profesional del área medica:	sumar por columna:	+	+	
	total:			

SAMPLE 3

Si tiene pensamientos de que es mejor estar muerto/a o hacerse daño de alguna manera, favor de hablar con su medico, ir a una sala de emergencia, o llamar al 911.

10. Si usted se identificó con cualquiera de los problemas mencionados en este cuestionario, que tan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

Nada en Absoluto	**Algo Difícil**	**Muy Difícil**	**Extremadamente Difícil**
☐	☐	☐	☐

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CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 (PHQ-9)

Durante las últimas 2 semanas, ¿qué tan seguido le han afectado cualquiera de los siguientes problemas? *(Marque con una "✔" para indicar su respuesta)*	**Para nada**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer las cosas	0	1	2	3
2. Se ha sentido decaído(a), deprimido(a), o sin esperanzas	0	1	2	3
3. Dificultad para dormir o permanecer dormido(a), o ha dormido demasiado	0	1	2	3
4. Se ha sentido cansado(a) o con poca energía	0	1	2	3
5. Con poco apetito o ha comido en exceso	0	1	2	3
6. Se ha sentido mal con usted mismo(a) – o que es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Ha tenido dificultad para concentrarse en cosas tales como leer el periódico o ver televisión	0	1	2	3
8. ¿Se ha estado moviendo o hablando tan lento que otras personas podrían notarlo?, o por el contrario – ha estado tan inquieto(a) o agitado(a), que se ha estado moviendo mucho más de lo normal	0	1	2	3
9. Ha pensado que estaría mejor muerto(a) o se le ha ocurrido lastimarse de alguna manera	0	1	2	3

SAMPLE 4

FOR OFFICE CODING ___0___ + ______ + ______ + ______

=Total Score: ______

Si usted marcó cualquiera de estos problemas, ¿qué tan difícil fue hacer su trabajo, las tareas del hogar o llevarse bien con otras personas debido a tales problemas?

Para nada difícil	**Un poco difícil**	**Muy difícil**	**Extremadamente difícil**
Ⓢ	Ⓢ	Ⓢ	Ⓢ

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PHQ9P

CUESTIONARIO SOBRE LA SALUD DEL PACIENTE-9 72883
(US Spanish version of the PHQ)

THIS SECTION FOR USE BY STUDY PERSONNEL ONLY.

Were data collected? **No** ☐ *(provide reason in comments)*

If **Yes**, data collected on visit date ☐ **or** specify date: ____________ DD-Mon-YYYY

Comments:

Only the patient (subject) should enter information onto this questionnaire.

Durante las últimas 2 semanas, ¿qué tan seguido ha tenido molestias por cualquiera de las siguientes dificultades?	**No del todo**	**Varios días**	**Más de la mitad de los días**	**Casi todos los días**
1. Poco interés o placer en hacer cosas	0	1	2	3
2. Sintiéndose decaído(a), deprimido(a), o sin esperanzas	0	1	2	3
3. Dificultad en caer o permanecer dormido(a), o dormir demasiado	0	1	2	3
4. Sintiéndose cansado o teniendo poca energía	0	1	2	3
5. Pobre de apetito o comer en exceso	0	1	2	3
6. Sintiéndose mal con usted mismo(a) – o que usted es un fracaso o que ha quedado mal con usted mismo(a) o con su familia	0	1	2	3
7. Dificultad en concentrarse en cosas, tales como leer el periódico o ver televisión	0	1	2	3
8. ¿Moviéndose o hablando tan lento, que otras personas podrían notarlo? o lo contrario – muy inquieto(a) o agitado(a) que usted ha estado moviéndose mucho más de lo normal	0	1	2	3
9. Pensamientos de que usted estaría mejor muerto(a) o de alguna manera lastimándose a usted mismo(a)	0	1	2	3

Scoring For Use By Study Personnel Only

0 + ______ + ______ + ______

=Total Score: ______

Si usted marcó cualquiera de los problemas, ¿qué tan difícil han afectado estos problemas en hacer su trabajo, encargarse de tareas del hogar, o llevarse bien con otras personas?

Para nada difícil	**Un poco difícil**	**Muy difícil**	**Extremadamente difícil**
☐	☐	☐	☐

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Confirmo que la información en este formulario es correcta.	Iniciales del paciente:	Fecha:

SAMPLE

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CUESTIONARIO DE LA SALUD DEL PACIENTE (PHQ-9)

NOMBRE: ______________________ **FECHA:** ____________

Durante las *últimas dos semanas*, ¿con qué frecuencia se ha visto afectado por los siguientes problemas? (marque su respuesta con "✓")	Nunca	Varios días	Más de la mitad	Casi todos los días
1. Tiene poco interés o encuentra poco placer en hacer las cosas.	0	1	2	3
2. Se siente desanimado, deprimido o sin esperanzas.	0	1	2	3
3. Tiene problemas para dormir o mantenerse dormido o duerme demasiado.	0	1	2	3
4. Se siente cansado o tiene poca energía.	0	1	2	3
5. Tiene poco apetito o come en exceso.	0	1	2	3
6. Siente falta de amor propio o que es un fracaso o que se ha decepcionado a sí mismo o a su familia.	0	1	2	3
7. Encuentra dificultad en concentrarse, por ejemplo, al leer el periódico o ver televisión.	0	1	2	3
8. Se mueve o habla tan lentamente que la gente lo puede haber notado o de lo contrario, está tan agitado o inquieto que se mueve mucho más de lo acostumbrado.	0	1	2	3
9. Tiene pensamientos de que sería mejor estar muerto o de que quiere hacerse algún daño.	0	1	2	3
suma de las columnas:		+	+	
TOTAL:				

SAMPLE 6

10. Si usted se identificó con cualquiera de estos problemas, ¿qué dificultad le han ocasionado estos problemas al hacer su trabajo, ocuparse de la casa o llevarse bien con los demás?

- **Ninguna dificultad** ______
- **Algo de dificultad** ______
- **Mucha dificultad** ______
- **Extrema dificultad** ______

PHQ-9 es una adaptación de PRIME MD TODAY, desarrollado por los doctores Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, y otros colegas con una subvención educativa de Pfizer Inc. Para información sobre estudios, comuníquese con Dr Spitzer en rls8@columbia.edu. PHQ-9 Copyright © 1999 Pfizer Inc. Todos los derechos reservados. Reproducido con permiso. PRIME-MD® y PRIME MD TODAY® son marcas registradas de Pfizer Inc.

PRIME-MD Patient Health Questionnaire – PHQ-9

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Durante las últimas 2 semanas, con que frecuencia le han molestado los siguientes problemas? (Utilice "✔" para indicar su respuesta)	**Nunca**	**Varios Días**	**Más de la Mitad de los Días**	**Casi Todos los Días**
1. Tengo poco interés o placer en hacer las cosas	0	1	2	3
2. Me siento desanimado/a, deprimido/a, o sin esperanza	0	1	2	3
3. Tengo problemas en dormirse o mantenerse dormido/a, o en dormir demasiado	0	1	2	3
4. Me siento cansado/a o tener poca energía	0	1	2	3
5. Tengo poco apetito o comer en exceso	0	1	2	3
6. Me siento con falta de amor propio - o que soy un fracaso o que me decepcionará a si mismo/a o a mi familia	0	1	2	3
7. Tengo dificultad para concentrarme en cosas tales como leer el periódico o mirar la televisión	0	1	2	3
8. Me muevo o hablo tan lentamente que otra gente se podría dar cuenta - o de lo contrario, estoy tan agitada/o o inquieto/a que me muevo mucho mas de lo acostumbrado	0	1	2	3
9. Se me han ocurrido pensamientos de que seria mejor estar muerto/a o de que haría daño de alguna manera*	0	1	2	3

SAMPLE 7

***** ***Si tiene pensamientos de que es mejor estar muerto/a o hacerse daño de alguna manera, favor de hablar con su medico, ir a una sala de emergencia, o llamar al 911.***

10. Si usted se identificó con cualquiera de los problemas mencionados en este cuestionario, que tan difícil se le ha hecho cumplir con su trabajo, atender su casa, o relacionarse con otras personas debido a estos problemas?

Nada en Absoluto	**Algo Difícil**	**Muy Difícil**	**Extremadamente Difícil**
☐	☐	☐	☐

APPENDIX C

EDSM Curriculum Comparisons

	Original Curriculum (Lara, Acevedo, Luna, Weckmann, Villarreal, & Pego, 1997)	Modified Curriculum (López-Arenas & Cano-Hays, 2005, unpublished)	Summary of Changes Made
Session 1	1. Introduction 2. Participant Presentation 3. Lecture 1: How to Use the Educational Material and Q & A 4. Lecture 2: What is Depression? and Q & A 5. Lecture 3: Forms of Thinking of Depressed People and Q & A 6. Review of key points 7. Home activities and closing	1. Introduction 2. Pre-test 3. Activity: Ice Breaker 4. Activity: Fishing Myths 5. Activity: Self-Care Plan 6. Activity: Participation/Self-Contract 7. Home Activities and Closing	Session was introduced as an introductory session and overview of topics that will be covered in the intervention. Session was designed to be engaging, fun, reflective, and a placeholder for participant recruitment in the case of low turnout.
Session 2	1. Review of Experiences and Home Activities 2. Lecture 4: Why Do We Get Depressed? and Q & A 3. Lecture 5: Childhood History and Q & A 4. Lecture 6: Life Events and Q & A 5. Review of key points 6. Home activities and closing	1. Pre-test 2. Introduction/Discussion of Home Actitivities 3. Activity: Ice Breaker 4. Activity: Workshop Agreements 5. Discussion & Reading: Lecture 2: What is Depression? 6. Discussion & Reading: Lecture 3: How Do Depressed People Think? 7. Home Activities	Session was designed to continue building rapport and trust among participants. Session integrates discussion about mental health stigma among Latino culture and similar to the original curriculum, sections of the curriculum are read (e.g., Lecture 2 & 3).
Session 3	1. Discussion of home activities 2. Lecture 7: Social Condition of Women a. How we Learn to Become Women and Q & A 3. Lecture 8: Social Condition of Women a. Partner Relationships and Q & A 4. Lecture 9: Social Condition of Women a. Role of a Housewife and Q & A 5. Review of key points 6. Home activities and closing	1. Discussion of Home Activities 2. Family Questionnaire 3. Activity: "Cristina Poster" 4. Activity: Guided Visualization 5. Home Activities	Rather than reading the book in session, participants are asked to engage in a series of activities that allow them to reflect on their personal lives (e.g., Lecture 5 & 6 of original curriculum) and its influence on their mental well being.
Session 4	1. Discussion of home activities 2. Objective & Activities for this Session 3. Exercise 1: What to do? Defining What Happens to Us 4. Exercise 2: Towards a Reassessment of Our Person" 5. Home activities and closing	1. Discussion of Home Activities 2. Activity: Gender Role Identification 3. Activity: Sex-Gender Card Sort 4. Activity: 100 Latinas Said (True or False) 5. Activity: Communicating about Sexuality 6. Home Activities	Authors recommend dedicating time to discuss sexuality as it is often requested by participants, which is consistent with this author's observation when first implementing and modifying the curriculum. The concepts of Lectures 7, 8, and 9 were converted to activities, which is in line with Adult Learning Theory.
Session 5	1. Discussion of home activities 2. Exercise 3: Changes in our Beliefs 3. Exercise 4: Modifying the Way we Perceive our Environment 4. Activity at Home: Exercise 5 5. Review of key points and closing	1. Discussion of Home Activities 2. Discussion: Institutions that Define Our Gender Roles 3. Activity: The Grain of Coffee 4. Activity: The Suitcase of Life 5. Discussion: Parting with Our Sadness, Fear, and Anger 6. Home Activities	Concepts learned in previous session are further examined in the context of participants' current lives. Participants are asked to reflect on their perception of themselves and reflect on current problem solving skills.

EDSM Curriculum Comparisons (continued)

	Original Curriculum (Lara, Acevedo, Luna, Weckmann, Villarreal, & Pego, 1997)	**Modified Curriculum (López-Arenas & Cano-Hays, 2005, unpublished)**	**Summary of Changes Made**
Session 6	1. Discussion of Home Activities 2. Exercise 5: New Ways of Behaving 3. Behavioral Contract 4. Lecture & Explanation: Where to Go? And Q & A 5. Workshop Closing	1. Discussion of Home Activities 2. Activity: Problems that Women Face 3. Activity: Young/Old Woman 4. Activity: 9 Dots Problem 5. Activity: Duncker's Candle Problem 6. Home Activities	Concepts from Exercise 3 & 4 of the original curriculum were converted to activities aligned with Adult Learning Theory. Participants are asked to engage in problem solving skill development activities.
Session 7	None	1. Discussion of Home Activities 2. Post-test 3. Activity Guide 4. Where to Go 5. Activity: Jewelry Making 6. Certificates/Graduation 7. Potluck and Closing of Workshop	Similar to the original curriculum, participants review of concepts learned throughout the training and discuss treatment options within their community. Modification includes a demonstration of a craft, each participant is awarded a certificate of completion, and at participants request, engage in a potluck and discuss sustainability of the groups and their continued communication with each other.

APPENDIX D

Araceli López-Arenas, PhD, MPH, MS is a San Diego native and she traversed state borders to Texas and Hawaii for her academic training in Counseling Psychology and Public Health. Araceli attended UC Irvine and earned a BA degree in Psychology and minors in Educational Studies and Chicano/Latino Studies in December 2005. She entered the Counseling Psychology program at Texas A&M University in August 2007 and received her Master of Science degree in Educational Psychology in August 2009. In conjunction with her doctoral program, she attended Texas A&M Health Science Center School of Public Health where she earned a Master's in Public Health in Social and Behavioral Health in May 2013. She completed an APA-accredited internship at the VA Pacific Islands Health Care System in Honolulu, HI in June 2014. She received her Doctor of Philosophy degree in Counseling Psychology in August 2016.

Her research interests involve exploring cultural factors related to health/mental health disparities and she is passionate about using her creativity to develop, implement, and evaluate programs that aim to reduce health disparities and increase access to care among underserved populations. She is passionate about working with Promotores de Salud/Community Health Workers (Promotores/CHWs) and engaging in community-based participatory health and mental health research. She is also involved in the dissemination and implementation of research ethics training for Promotores/CHWs.

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