

The Interplay of Risk and Resilience among Hispanic Teen Mothers

with and without Depression

A thesis submitted by

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In partial fulfillment of the requirements for the degree of

Master of Arts

in

Child Study and Human Development

TUFTS UNIVERSITY

August 2015

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Abstract

Though they are vulnerable to a number of risks including the development of depression, Hispanic teen mothers are a relatively understudied population (Beers & Hollo, 2009; Koleva & Stuart, 2014). Utilizing a risk and resilience framework, this study investigated the presence of depression in this population as a byproduct of cumulative risk and insufficient buffering from protective factors. Subsequently, the study utilized an interpretive method to examine specific risk and protective factors that Hispanic teen mothers reported, as well as how they expressed their experiences with depression and services available to them. The findings of this study and related implications have the potential to contribute to extant knowledge about Hispanic teen mothers and to spur future research, with the ultimate hope of enhancing outcomes for members of this population and their children.

Acknowledgments

This thesis has been an incredible learning process for me, both academically and personally. I could not have made it through this process without the patience and unconditional support I received from my adviser, Jayanthi Mistry, and for that I am eternally grateful. I would also like to thank my committee members Sasha Fleary and Virginia Diez for their invaluable input. Additionally, I would like to thank Judith Scott, Ellen Pinderhughes, Martha Pott, and the entire Center for Promise team for providing me with relentless encouragement and guidance. I would also like to thank my family and best friend, for being there for me when I could not be there for myself. Finally, I would like to thank the senior team of the Massachusetts Healthy Family Evaluation for allowing me to use their data, and all the faculty and students in Eliot Pearson Department of Child Study and Human Development, who have supported me tremendously in my six years at Tufts University. I am forever touched by your kindness.

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Chapter 1: Introduction

Though teen pregnancy has reached its lowest rates since the early nineties, racial disparities still exist, as Hispanic youth are twice as likely to become pregnant as their White counterparts (Kost & Henshaw, 2014). The disproportionate rate of teen pregnancy among Hispanic¹ females is arguably symptomatic of the equally disproportionate risks that many of these young women face, including a lack of resources due to low socioeconomic status (Penman-Aguilar et al., 2013). Many of these risks persist after childbirth, as teen mothers are more likely to experience school failure and dropout, to be dependent on government support, and to experience mental health problems such as depression and chronic stress (Beers & Hollo, 2009).

The risk of depression, in particular, is commonly and mistakenly overlooked among Hispanic teen mothers (Koleva & Stuart, 2014). Rates of depressive symptoms are higher among Hispanic youth than among their White and Black counterparts (Centers for Disease Control and Prevention, 2014), and adolescent motherhood may exacerbate the risk of depression through the significant increase of stress (The Schuyler Center for Analysis and Advocacy, 2008). Adolescent maternal depression has also been linked to increased rates of

¹ The term *Hispanic* is used in this paper to refer to members of ethnic groups originating from Spanish-speaking nations in Latin America and Spain (Passel & Taylor, 2009). However, this aggregate label does not do justice to the wealth of ethnic and cultural heterogeneity that is represented within the group

other mental health disorders or concerns, including psychiatric hospitalization and attempts of suicide. Moreover, these effects may extend to future generations. Indeed, Cox et al. (2008) explain that adolescent maternal depression can lead to less supportive care for children, indicating that the latter are deprived of caregiver warmth and attention at times when these elements are vital for healthy child development. Cox et al. (2008) found that these children may go on to exhibit more internalizing behaviors later in life. Thus, understanding the experience of depression will ultimately allow for proper prevention and targeting of potentially adverse outcomes for mothers and their children.

It is essential to acknowledge, however, that even in the context of myriad risk factors, some Hispanic teen mothers show great resilience and do not experience depression. Consistent with a Risk and Resilience framework, it is likely that these mothers' positive outcomes occur as the result of the interplay of risk and protective factors, wherein protective factors serve as buffers from the adverse effects of risk factors. When protective factors provide sufficient buffering, *resilience*, or "successful adaptation in the presence of risk or adversity" (Jenson & Fraser, 2006, p. 13) emerges. Thus, it is also important for research to examine the interplay of risk and protective factors, particularly focusing on the conditions under which resilience does or does not emerge.

The purpose of this thesis is to examine the interplay of risk and resilience among Hispanic teen mothers with and without depression, particularly as it relates to participants' experiences with depression, as well as risk and protective factors. This thesis is designed to also understand how these young mothers

utilize services available to them to ameliorate or optimize their circumstances. Accordingly, in an effort to provide a background for the study proposed thereafter, the next chapter begins by reviewing extant research on the most frequently reported risk and protective factors to which Hispanic teen mothers may be exposed, as well as on the manifestation of depression in this population. The chapters that follow elaborate on the study conducted, including the analysis, results, discussion, and future implications of the project.

Chapter 2: Literature Review

Common Sources of Risk for Hispanic Teens and Hispanic Teen Mothers

Hispanic teens may face increased risk for pregnancy that is contingent on their socioeconomic status (Child Trends, 2013) and nativity (Manlove et al., 2013). Penman-Aguilar et al.'s (2013) meta-analysis found that low socioeconomic status increases the likelihood of teen birth through the mediation of low parental education; residence in neighborhoods with low per capita income, high income inequality, and high physical disorder (presence of graffiti, beer or alcohol containers, cigarette butts, litter or glass, and abandoned vehicles); high school dropout; and having a mother who herself was a teen mother. Hispanic youth are highly likely to experience these circumstances as almost two-thirds of all Hispanic children grow up in low-income households (compared to less than one third of White children; Addy & Wright, 2012).

In addition to potential disadvantages related to socioeconomic status, Hispanic teens may be at greater risk for pregnancy depending on their nativity. Indeed, important differences related to childbirth have been found between US-

born and foreign-born Hispanics. Manlove et al. (2013) found that when compared to Whites, foreign-born Hispanics are 3.5 times more likely to have a teenage birth, while US-born Hispanics are 1.9 times more likely. The authors posit that the discrepancy between Hispanic groups might be related to acculturation, defined as the “process by which a person adapts to a new culture and adopts [its] values, beliefs, and behaviors..., while maintaining elements of the culture of origin.” (Zayas & Platt, 2008). While it may be more normative among Hispanic cultures to have children earlier, US-born Hispanics may not adhere as much to these expectations as foreign-born Hispanics because of greater assimilation into mainstream American culture (Manlove, et al., 2013).

Manlove et al. (2013) also point to familial and sexual behavior factors that may contribute to the discrepancy in teenage pregnancy between foreign-born and U.S.-born Hispanic groups. More specifically, foreign-born Hispanic teens are more likely than their US-born counterparts to grow up in households where there is lower parental education, the absence of two biological parents, and a mother who herself had a teenage birth, which are all factors that have been found to lead to teen pregnancy. Furthermore, although foreign-born Hispanics have sex later than those who are US-born (Blum, 2000), the former are less likely to use contraceptives consistently and efficaciously (McDonald, Manlove, & Ikramullah et al., 2009).

Several mechanisms have been identified to explain why foreign-born Hispanic girls may use contraceptives infrequently. Firstly, a majority of Hispanic teens do not hold positive views of contraception, and do not communicate openly

with their partners about sex or contraception (Griffin, Lesser, Uman, & Nyamathi, 2003). The lack of communication, in turn, may be due to the fact that Hispanic teen girls are likely to choose partners that are on average three years older. The age difference creates a power dynamic that pushes girls to avoid asking for contraception, in fear of losing the trust of their partner (Goodyear & Newcomb, 2002). Girls in these relationships may also fear abuse and/or retaliation from their partner if trust is compromised. Finally, older partners may initiate sex at an earlier age, when younger girls may not be emotionally prepared to address issues of contraception and pregnancy (Griffin et al., 2003).

In sum, socioeconomic status and variations related to nativity are found to significantly influence the discrepancy in pregnancy rates between Hispanic girls and girls of other ethnicities, as well as that between US-born Hispanic girls and their foreign-born counterparts. Furthermore, these factors may continue to pose risks for adverse outcomes once Hispanic teens become mothers. Issues of nativity may also pose further risks for foreign-born teen mothers who lack proper immigration documentation. In the United States, over one million foreign-born Hispanic individuals under the age of 18 are undocumented (Fry & Passel, 2009). Hispanic teen mothers who are undocumented may face greater systemic and psychological barriers than their US-born counterparts. Due to their immigration status, undocumented mothers may have less access to health insurance, as well as fewer opportunities to pursue higher education and economic growth (Marshall, Urrutia-Rojas, Soto Mas, & Coggin, 2005). Limited access to health care often means that these mothers begin prenatal care later and have fewer prenatal visits

than pregnant women in the general population (Fuentes-Afflick et al., 2006; Reed, Westfall, Bublitz, Battaglia, & Fickenscher, 2005). As a result of delays in accessing healthcare, birth complications such as excessive bleeding and fetal distress are also more common among undocumented women relative to those who are documented (Reed et al., 2005). These circumstances can lead to detrimental health outcomes for mothers and their children.

It is also the case that undocumented individuals may experience heightened psychological distress due to their immigration status. This distress may occur as a result of guilt and shame from violating immigration laws, of intense fears of being discovered by Immigration authorities, and of being torn apart from their families through deportation. These distressing factors can have serious psychological consequences including increased anxiety and depression (Cavazos-Rehg, Zayas, & Spitznagel, 2007; Sullivan & Rehm, 2005).

The status of undocumented individuals is often confounded with their ethnicity, such that people of other ethnicities may assume that all Hispanics are undocumented. As a result, it is also likely that Hispanic teen mothers, regardless of their nativity, will experience discrimination by virtue of their ethnicity (Sullivan & Rehm, 2005). A recent national survey of Hispanics revealed that a third of all participants had personally experienced ethnic discrimination or had a member of their family or a close friend who had in the past five years (Lopez, Morin, & Taylor, 2010). Other studies have reported this prevalence to be consistent among Hispanic teen mothers in particular as well (National Women's Law Center, 2009). Some of the commonly held stereotypes against this

population include being “lazy, overemotional, unreliable, illegally in the United States, speaking broken English, and criminal” (Delgado-Romero, Galván, Hunter, & Torres, 2008, p. 331). The experience of discrimination has been found to be positively correlated with depression (Hwang & Goto, 2008), anxiety (Alamilla, Kim, & Lam, 2010), symptoms of post-traumatic stress (Flores, Tschann, Dimas, Pasch, & De Groat, 2010), and lowered academic motivation (Alfara, Umaña-Taylor, Gonzales-Backen, Bamáca, & Zeiders, 2009) and job satisfaction (Foley & Kidder, 2002).

In addition to discrimination, it is also likely that Hispanic teen mothers may experience stigma due to their early motherhood. Indeed, the stigma related to teenage motherhood has risen in the past century as a result of various historical events. For instance, though pregnancies among older teens were common in the 1950s and earlier, decades since have seen a sharp rise in criticisms of teen parenting, pointing to the adverse outcomes of mothers and their children (Furstenberg, 2007). These criticisms have led to a shift in the public discourse regarding teen parenting, and have been accompanied by the expansion of the labor market, the growth of universities, and the legalization of birth control and abortion (CDC, 2012). As a result, teen mothers have since been depicted as unproductive members of society at large, since having a baby is perceived as disrupting education, undermining professional growth, and leading to welfare dependence (SmithBattle, 2013).

Perhaps aggravating the stigmatized view of this population is the fact that studies related to outcomes of teen mothers and their children often overlook

mothers' prior circumstances (SmithBattle, 2012). Indeed, SmithBattle (2013) argues that if adjusted for childhood disadvantages, the outcomes of teen mothers and their children are similar to those of older mothers and their children of the same background, suggesting that age of mother at childbirth may not be as important as commonly thought.

The experience of stigma may be highly prevalent among teen mothers. In one study including Hispanic young women, Wiemann, Rickert, Berenson, and Volk (2005) reported that 39% of teens on a postpartum unit in a Texas hospital felt stigmatized. In other research, mothers have identified the most common sources of stigma as media reports and strangers who glare at them or verbally criticize them in public (Fulford & Ford-Gilboe, 2004; Gregson, 2009; Higginbottom et al., 2006). Mothers also commonly report that social service and school staff are rude and judgmental of their circumstances (Horowitz, 1995; Silver, 2008), and that clinicians treat them disrespectfully, doubting their ability as mothers (Brubaker, 2007; Fessler, 2008). As a result, mothers who are subjected to stigma often feel resentment, fear, shame, anger, and worthlessness (Yardley, 2008).

Risk Factors and Depression

As noted above, Hispanic teen mothers are likely to experience risk factors that lead to their pregnancy, and to continue to be exposed to risk factors that predispose them to adverse outcomes after childbirth. In addition, maternal depression is prevalent among as many as 30% to 59% of adolescent mothers, and those who Spanish speaking or bilingual report higher rates of depression than

English speaking mothers (Nadeem, Whaley & Anthony, 2006). The extent to which risk factors and adverse outcomes jeopardize these mothers' psychological well-being and thus lead to depressive symptomatology is alarming, specifically because of the devastating consequences of depression for mothers and their children (Beers & Hollo, 2009). For adolescent mothers, depression has been found to lead to later substance use, delinquency, adverse life events, and persistent mental health problems including psychiatric hospitalization and suicidal attempts (Cox et al., 2008; Oxford, Gilchrist & Gillmore, 2006). Moreover, depressed mothers report decreased confidence in their parenting abilities and lowered perceived social supports, making them vulnerable to poor parenting (Cox et al., 2008).

Similarly, the children of depressed adolescent mothers are likely to experience a host of negative consequences. Infants of depressed mothers are less likely to look at their mothers, show less positive affect, and have lower physiological reactivity (Weinberg & Tronick, 1998). Later, these children are likely to display greater levels of socio-emotional problems and lower language skills compared to children of mothers without depression (Pascoe, Stolfi, & Ormond, 2006). Finally, depressed adolescent parents and their children experience more conflict in their relationship such that the children are likely to exhibit behavior problems at age three (Leadbeater, Bishop & Raver, 1996).

A subsequent concern related to the prevalence of depression is whether those affected are seeking and accessing appropriate services. Huang et al. (2006) suggest that though they experience significant rates of mental health issues,

mothers of racial/ethnic minorities and those who are foreign-born are less likely to seek services, or to think that they need services. Indeed, mothers experiencing depression may be afraid of discussing mental health concerns and/or may lack education about the disorder (NIHCM, Foundation, 2010).

Cultural attitudes about depression can also significantly influence the likelihood of seeking out appropriate services. Particularly, among some Latinos, symptoms of depression may be mistaken for nervousness, fatigue, or a physical disorder, and may thus be perceived as transient (APA, 2014). The misinterpretation of psychological symptoms translates into fewer attempts to access adequate care. Indeed, among Hispanics with a mental disorder, less than 1 in 11 contact a mental health professional, and less than 1 in 5 contact a primary care physician. Among Hispanic immigrants, these numbers are even lower (Surgeon General, 2011). Instead, Hispanic individuals who experience depressive symptomatology may reach out to extended family and community members, traditional healers, and/or religious leaders when experiencing a crisis (APA, 2014).

Additional barriers to accessing mental health care may include economic barriers related to costs of therapy and lack of health insurance, stigma, language barriers, and a lack of culturally appropriate services (APA, 2014). These problems may be aggravated for undocumented immigrants who do not qualify for health insurance. This population may thus experience cumulative risk for adverse outcomes due to the previously discussed risk factors associated with

their immigration status, the subsequent potential for depression, and their inability to access appropriate mental health care (Fortuna & Porche, 2013).

In sum, it may be likely that many Hispanic teen mothers who experience depression may never receive the care that they need because of fear, lack of education, cultural attitudes, stigma, and in some cases, unauthorized immigration status. Therefore, it is important to examine the extent to which interventions targeted at improving outcomes for teen mothers also enhance the accessibility of mental health services when needed.

Types of Depression and Symptoms

Though depression is commonly perceived by the lay public as a single disorder, there are several types identified in the literature that vary in terms of severity as well as the length of time for which they occur. Among the types of depression that have been identified are *Clinical or Major depression*; *Post-natal or Post-partum depression*; and *Situational or Reactive depression* (Harris and White, 2014). *Clinical or Major depression* is the most severe type of the disorder, lasting for at least two weeks but usually extending for prolonged periods of time, and causing serious disruptions to an individual's functioning and well-being (Hall-Flavin, 2014). *Post-partum depression* is classified under Major Depression and entails irritable, severely depressed mood that occurs within four weeks of giving birth (Andrews-Fike, 1999). *Situational depression* is a transient experience precipitated by a significant life event such as the death of a loved one or divorce; given the nature of this disorder, *Post-partum depression* is sometimes

classified as *Situational depression* because it occurs after the major life event of childbirth (Harris and White, 2014).

Different types of depression may share common symptoms including feelings of guilt or low self-worth; disrupted sleep or appetite; irritability; lack of energy; pessimism; withdrawal; chronic physical pain; poor motivation; and poor concentration (Harris and White, 2014). In order to distinguish among the different types, mental health professionals utilize the Diagnostic and Statistical Manual for Mental Disorders, Fifth Edition (DSM-5), which designates specific diagnostic criteria for each disorder (Kupfer, First, and Regier, 2002). Despite the existence of multiple types of depression, however, little is known about the types most prevalent among Hispanic populations, with most research focusing on *Clinical depression* more generally.

Common Protective Factors for Hispanic teen mothers

Despite the abundance of risk factors for Hispanic teen mothers found in extant literature, it is important to note that not all of these mothers experience depression. Indeed, framing this population's contexts solely as risky is a disservice to the myriad of protective factors that these mothers may experience. Moreover, this framework may be disempowering, as it conveys to both teen mothers and those around them that the former are helpless in escaping exposure to risk factors and consequent adverse outcomes.

Consistent with a risk and resilience framework (Jenson & Fraser, 2006), Hispanic teen mothers who exhibit resilience in the context of risk factors are also exposed to a number of protective factors that act as significant buffers against

adverse effects. Among these protective factors, the most salient can be categorized as cultural or cognitive. One of the cultural protective factors that Hispanic teen mothers may experience is *familism*, typically found to be high among Hispanic families. *Familism* refers to a strong orientation toward the family, as well as adherence to family values that underscore interdependence, support, and obligation to one another. For adolescent mothers, *familism* may serve several functions, including the provision of emotional and instrumental support to help ease the transition into motherhood (Organista, Organista, & Kurasaki, 2003; Umaña-Taylor, 2010).

Another phenomenon observed among Hispanic youth and families is the *Immigrant Paradox*. According to Hernandez, Denton, Macartney, and Blanchard (2012), this concept refers to the idea that “first- and second-generation children² in many immigrant groups are, in fact, doing about as well as or better than their peers in native-born families along many dimensions” (p. 17). This concept poses a paradox precisely because despite the number of risk factors to which recent immigrants may be exposed, research has shown that these populations exhibit resilience in various dimensions, including health (i.e., lower indices of physical health problems, obesity, asthma, emotional issues) and risky behaviors (i.e., less instances of early sexual experience, substance use/abuse, delinquency, violent behavior and use of weapons) (Hernandez et al., 2012). Compelling evidence has been found for fewer health problems and risky behaviors among adolescents

² *First generation* refers to individuals who are foreign-born, or US-born with at least one parent who is foreign-born. *Second generation* refers to those who are the children of first generation individuals.

from Mexico, Cuba, Central/South America, Puerto Rico, China, Philippines, Africa, Afro-Caribbean, Europe, and Canada (Harris, 1999).

Research has shown variations in the *Immigrant Paradox* among immigrant groups. Particularly, some studies have reported differences between foreign-born and US-born individuals (as opposed to differences among individuals of different generations), showing that the former group tends to fare better than the latter. For example, Alegria et al. (2008) found that foreign-born Hispanics may be less susceptible to developing lifetime psychiatric and substance abuse disorders compared to Hispanics who are US-born. Reporting similar findings, Denner (2001) explains that mediators for the *Immigrant Paradox* may include increased resilience resulting from the immigration experience, as well as close ties to the home country through the immigrant community.

Though these variations of the *Immigrant Paradox* offer different perspectives regarding the beneficiaries (first- and second-generation versus later-generation immigrants; foreign-born versus US-born individuals), the underlying effect is consistent between the variations, such that recent immigrants are found to fare better in specific domains than individuals who have been in the United States longer. Thus, it is likely that Hispanic teen mothers' recency of immigration may serve as a protective factor against certain adverse outcomes (i.e., risky behaviors; physical, psychiatric, and substance abuse disorders).

In addition to possible culturally situated protective factors, there are also cognitive protective factors in which Hispanic teen mothers may engage.

Cognitive protective factors refer to adaptive ways in which individuals choose to think about or perceive their circumstances. These factors are at play for Hispanic teen mothers when the latter are buffered from specific risk factors, such as stigma and discrimination, whose operant mechanisms involve creating distortions in cognition. More specifically, stigma and discrimination can lead to adverse circumstances because they cause individuals to believe that they are inferior to others in society because of given characteristics that they may possess (i.e., being an adolescent mother and being Hispanic). Many teen mothers who do not experience adverse effects of stigma engage cognitive protective factors through which they choose to de-identify from stereotypes, and instead perceive themselves as more motivated and capable than other mothers (Gregson, 2009; Yardley, 2008). Some mothers also choose to view motherhood as a source of motivation to strive for better outcomes, and thus return to school, avoid risky behaviors, and leave abusive relationships (Gregson, 2009; Middleton, 2011; Yardley, 2008). Similarly, Hispanic adolescent mothers who are not negatively affected by discrimination maintain positive constructs about the self and others (Foley & Kidder, 2002; Moradi & Risco, 2006; Pascoe & Smart Richman, 2009). These mothers also cultivate effective coping skills to address their experiences of discrimination in adaptive ways (Pascoe & Smart Richman, 2009; Umaña-Taylor, Vargas-Chanes, Garcia, & Gonzales-Backen, 2008).

Therefore, though there are abundant discussions in popular discourse and extant literature about risk factors to which Hispanic adolescent mothers may be exposed, there is also significant evidence for protective factors. The existence of

both protective and risk factors warrants examination of the interplay of the two, particularly focusing on how, or under what dynamics among factors, adverse outcomes such as depression or positive outcomes of resilience may emerge.

Examining the Interplay of Risk and Protective Factors among Teen

Mothers with Elevated and Low levels of Depression

In order to best examine the nuanced ways in which risk and protective factors may interact, the most appropriate method of inquiry is to explore the narratives of Hispanic teen mothers through the qualitative method of narrative analysis. Using this method, particular features such as mothers' individual reports of their circumstances, framing of their experiences, coping skills, and self-appraisal can be extracted from their personal accounts.

Accordingly, the aim of this study will be to answer the following two questions: 1. Are there consistent ways in which the experiences of Hispanic teen mothers with chronically elevated levels of depression differ from those of Hispanic teen mothers who do not endorse elevated levels of depression? 2. Are there differences between the two groups of mothers in terms of how they use the Healthy Families program as well as more specific mental health services other than the home visiting program?

The first research question proposed in this study intends to explore any and all of the ways in which the experiences of Hispanic teen mothers with depression differ from those of Hispanic teen mothers without depression. Given this exploratory objective, no hypothesis will be made regarding the specifics of what will arise from analyses of participants' experiences. However, a hypothesis

will be made in reference to participants' reports of risk and protective factors that may be identified through the analysis. Particularly, recalling the Risk and Resilience framework previously introduced in this paper (Jenson & Fraser, 2006), the experience of depression is herein conceptualized as an adverse outcome resulting from significant risk and a lack of sufficient protective factors. Therefore, I hypothesize that the Hispanic teen mothers with depression will report greater amounts of risk factors and fewer protective factors, as well as more severe risk factors, than the Hispanic teen mothers without depression.

Regarding the second research question, literature previously reported in this paper notes that Hispanic populations with mental illnesses may not utilize appropriate mental health services when needed (Surgeon General, 2011). Therefore, I hypothesize that Hispanic teen mothers with depression will not necessarily report greater access of mental health services nor differential ways in which they use the Healthy Families program, compared to the Hispanic teen mothers without depression.

Chapter 3: The Current Study

Healthy Families

The Healthy Families Massachusetts newborn home visiting program (HFM) is a comprehensive, voluntary program for first-time parents aged 20 and under residing in the state of Massachusetts. An affiliate of *Healthy Families America* (HFA), HFM provides young parents with parenting support, information, and services from pregnancy until the child's third birthday. HFM services include home visits, goal-setting and group-based activities, secondary

contacts (i.e., phone calls with home visitors), and connections and referrals to other services. The program is designed to target five specific goals, namely:

1. “To prevent child abuse and neglect;
2. To promote optimal child development;
3. To encourage educational attainment, job, and life skills among parents;
4. To prevent repeat pregnancies during the teen years;
5. To promote parental health and well-being” (Tufts Interdisciplinary Evaluation Research, 2013).

In 1997, researchers from Tufts University’s Departments of Child Development, and Urban and Environmental Policy and Planning were chosen to conduct an evaluation of HFM. The first cohort evaluation (MHFE-1) began in 1997 and ended in 2005; the second cohort evaluation, currently in progress, began in 2007 (MHFE-2), and consists of an ongoing randomized controlled trial (RCT; Tufts Interdisciplinary Evaluation Research, 2013).

Participants for the evaluation were recruited through HFM local and state personnel as well as MHFE-2 researchers at Tufts University. A total of 704 enrollees were randomly assigned to either the Home Visiting Services group (HVS; program group; 433 or 62%), or the Referrals and Information Only group (RIO; control group; 271 or 38%). HVS participants receive services as usual whereas RIO participants receive information about child development and referrals to other services (Tufts Interdisciplinary Evaluation Research, 2015).

In the beginning of the RCT, young mothers from both groups participated in a half-hour intake interview and an in-person research interview at times 1 (T1; completed at enrollment), 2 (T2; completed 12 months after enrollment), and 3 (T3; completed 24 months after enrollment). Information collected from participants at both interviews included demographics (i.e., age, ethnicity); family resources and participation of the baby's father; financial status; and maternal well-being (i.e., stress, depression, PTSD). According to self-reports from T1 intake interviews, participants were on average 18.6 years old and babies' fathers were on average 20.9 years old. 37% and 36% of participants identified themselves as non-Hispanic White or Hispanic, respectively, while the remaining 19% and 8% identified themselves as non-Hispanic Black or non-Hispanic Other (Tufts Interdisciplinary Evaluation Research, 2013).

Sixty-six percent of HVS mothers and seventy-five percent of RIO mothers completed the more comprehensive in-person research interview. During this assessment, young mothers participated in a semi-structured interview and an observation of mother-child interactions, and filled out written questionnaires. This portion was used to collect data on participants' social relationships and support network, the mother's childhood, educational experiences, history of intimate partner violence, and personal functioning (Tufts Interdisciplinary Evaluation Research, 2013). Since the interviews were semi-structured and relatively open-ended the participants provided rich and detailed information that reflected how they were making sense of their life circumstances and reactions.

Thus, due to their comprehensive nature, this study uses data from MHFE-2 to answer the research questions herein discussed.

Research Design

This study was designed to use an interpretive approach (Miles, Huberman, & Saldaña, 2013) to closely examine thirty-four mothers' narratives of their life experiences to identify exactly what underlying risk factors, as well as protective factors, may be evident among participants' stories. The qualitative approach also allowed for the exploration of whether factors such as participants' framing of their experiences, their coping mechanisms, or their appraisals of themselves as parents and individuals, can help account for differences between Hispanic teen mothers who experience clinically elevated symptoms of depression and those who do not. The proposed study was also designed to compare participants who were in the HVS group with those in the RIO group, to specifically focus on whether HVS services are utilized towards mental health issues and to what extent mental health services other than HVS are utilized.

Sample Selection

The sample for this study was selected using SSPS, a software program commonly utilized for statistical analysis. Participants were selected from the greater overall MHFE sample of 704 participants. Criteria for selection included participation in all three waves of the study, in order to maximize consistency in the amount of information attained from participants; and self-identification as "Hispanic" in demographic intake questionnaires. Participants' specific Hispanic

heritage was not used as a selection criterion due to the already limited pool of Hispanics from which to select.

In order to identify participants who had clinically elevated levels of depression and those who did not, scores from all three time points of the administration of the Center for Epidemiologic Studies Depression Scale (CES-D; Radloff, 1977) were used. The CES-D (range: 0-60) is a widely utilized 20-item self-report inventory that measures symptoms of depression occurring in the past week. Subjects are considered to have depression if they have a CES-D score of 16 or higher. The inventory has tested validly and reliably with diverse populations, including Hispanics (Naughton & Wiklund, 1993).

Participants selected for the two clinically depressed (CD) groups in this study met CES-D criteria of clinically elevated levels of depression (scores greater than or equal to 16) at all three times points. On the other hand, participants selected for the non-clinically depressed groups (NCD) had scores less than or equal to 12, in order to minimize the possibility of sub-clinical depression existing in participants in the NCD groups. Finally, half of CD and NCD participants were in the HVS condition of the RCT, and half were in the RIO condition. All together, the selection criteria yielded a maximum of eight participants in each of the CD groups, and nine participants in each of the NCD groups (See Appendix I for descriptive information regarding the participants in the sample). Participants' qualitative interviews were transcribed by members of the MHFE team and ranged from 7 to 32 single-spaced pages at T1, 1 to 12 single-spaced pages at T2, and 4 to 13 single-spaced pages at T3. These page

ranges demonstrate the rich amount of detail provided by participants in their narratives.

Data Analysis

Data from participants' semi-structured interviews were analyzed using interpretive methods through the following steps. First, transcripts of the interviews (previously prepared by members of the MHFE team) were examined in ATLAS.ti (a software commonly used for qualitative analysis) to identify preliminary coding categories representing the constructs (i.e., risk factors, protective factors) pertinent to the research focus. Two to three interviews from each of the four groups were coded such that relevant text that referred to the constructs was "tagged" (i.e., labeled). The quotes tagged for each construct were then retrieved across all eight to twelve interviews to examine the nature and extent of variation. Such variation among participants validated the constructs identified, and the rest of the interviews were similarly coded by tagging quotes pertinent to each of the coding categories.

Coding Scheme. The main constructs that arose from the preliminary analysis of the data, and that were incorporated in the final coding scheme were:

1. Family Relationships: Participants divulged in detail about the familial relationships they had while growing up.
2. Educational History: Participants described their educational trajectories including moves between schools because of suspensions, expulsions, and/or housing instability, as well as special education

received for a variety of reasons (i.e., specific classes or school for teenage mothers).

3. Cultural Scripts and Experiences: Participants described experiences related specifically to their cultural background.
4. Immigration Experiences: Foreign-born participants reported on their experiences immigrating to the United States.
5. Depression and Suicidal Ideation (SI): Participants described their experiences with depression and SI, as well as depressive symptomatology.
6. Supports and Protective Factors: Participants reported on factors and experiences that seemed to have buffered them from certain adverse outcomes.³
7. Stressors and Risk Factors: Participants described events and factors that seemed to have spurred certain adverse consequences.²
8. Agency: Participants demonstrated the ability to act independently and exert influence upon their circumstances. This ability is often referred to as *agency* in the Social Sciences (Barker, 2000).
9. Framing: Participants communicated in ways that expressed their feelings and attitudes about their experiences.
10. Mental Health Services: Participants reported on their utilization of mental health services.

³ This working definition was extracted from the Risk and Resilience framework (Jenson & Fraser, 2006) previously discussed in this paper.

11. HFM Use: Participants described the ways in which they utilized Healthy Families services, as well as the nature of their relationship with their home visitor.

Once these coding domains were finalized, a total of ninety-nine transcripts (thirty-four participants across three time points) were examined and where relevant, the coding domains were used to tag quotes in participants' narratives. The resulting quotes were, in turn, extracted from Atlas.ti and analyzed for patterns. Where such patterns emerged, corresponding quotes were organized into subcategories (presented in the following chapter), which were then put into charts for further analyses between and within groups of participants. The final step entailed constructing charts to represent observed patterns. The following chapter presents the results yielded from these analytical steps.

Chapter 4: Results

This chapter presents the findings of the analysis conducted using the eleven coding categories discussed above. For sake of clarity, the chapter is organized by research question, with two main subsections.

Research Question #1

The first question in this study stated, *Are there consistent ways in which the experiences of Hispanic teen mothers with chronically elevated levels of Depression differ from those of Hispanic teen mothers who do not report elevated levels of Depression?* To address this question, the responses of participants in the Non-Clinical Depression groups (NCD) were compared to those of participants in the Clinically Depressed groups (CD) on all of the coding categories. Differences

were apparent on five of the eleven coding categories. This chapter presents the patterns that arose from these four categories, namely *Depression*, *Stressors/Risk Factor(s)*, *Supports/Protective Factor(s)*, and *Agency*.

Depression. Of the thirty-four participants in the overall sample for this study, fourteen (41%) explicitly mentioned that they had experienced, or were currently experiencing, depression. Eight (57%) of these participants were in NCD groups, while six (43%) were in CD groups.

Themes from Participants' Reports of Depression. Three salient themes arose from participants' reports of depression. The first theme was *time frame*, whereby participants situated their experiences with depression in the past or present. The second theme was *situation-specificity*, through which participants described their experiences as the result of a specific event or situation, a feature that rendered these experiences akin to *situational depression*. Relatedly, the last theme was *transience*, where participants described their experiences as fleeting states.

Time frame - Depression as a Past or Present Occurrence. Almost all of the participants (13 out of the 14; 93%) who explicitly reported depression situated their experiences as having occurred in the past (9 participants; 69%) or in the present (4 participants; 31%). One (7%) participant did not elaborate on the circumstances of her depression, such that it was unclear whether it occurred in the past or if it was currently occurring. Interestingly, of the participants who reported experiences in the past, six (67%) were in the NCD groups, while three (33%) were in the CD groups. Moreover, of the four participants who reported

their experiences with depression in the present, two (50%) were in CD groups while two (50%) were in NCD groups. Thus, it seems that some participants without clinical levels of depression saw themselves as currently experiencing depression, and some participants with clinical levels of depression saw themselves as no longer having the illness. Though these quantities of participants are small and cannot be examined for significance, they may nevertheless present potential implications, which will be discussed in the next chapter.

Participants who situated their experiences in the past, whether in the NCD or the CD groups, tended to describe these experiences in the past tense and thus as no longer occurring. For example, when describing her childhood, participant 1258 reported, “I used to be depressed and lonely.” 1258’s statement situated her experience with depression in the past and implied that it was no longer happening. Similarly, participant 1487 explained, “There was only one time in my life that I was very depressed...” Similar to participant 1258, participant 1487’s report demonstrated that she experienced her depression in the past and implied that it had ended. Notably, participant 1258 had clinically elevated levels of depression at all three time points, while participant 1487 did not. A total of three participants in the CD groups, including participant 1258, reported their experiences with depression as having occurred in the past.

On the other hand, participants who situated their experiences with depression in the present reported these as current circumstances. For example, participant 1055 briefly explained, “I’m in depression.” Unlike previous participants whose reports of depression situated their experiences in the past,

participant 1055's statement placed her depression in the present, suggesting that it was still occurring at the time of her interview. Similarly, participant 1360 described, "Sometimes I get depressed and I don't want to do nothing." Participant 1360's experience with depression seemed to be an ongoing occurrence, albeit intermittent. It is important to point out that though *both* of these participants expressed that they had current experiences with depression, participant 1055 did not have clinically elevated levels of depression at any of the three time points, while participant 1360 did.

Transience. This theme is related to, yet distinct from the theme of *time frame* presented above. Particularly, it is also a temporal feature but refers to the length, as opposed to the time placement, of the event. Six (43%) of the participants who reported experiences with depression described these experiences as transient. For example, participant 2294 explained that her depression was contained within the length of her pregnancy. She reported, "When I was pregnant with [daughter's name], I was on depression." She later stated that her depression subsided when she got a job and no longer had time to "think anything." Similarly, participant 2050 described her depression as something that came and went, as opposed to a stable state. Relating the support that she received from her family, she stated, "When I feel depressed or sad [] they always talk to me and take me places [] so I wouldn't be upset."

In contrast, three participants did not ascribe transience to their depression, but rather reported it as more chronic states. The first participant, 1087, stated that during her childhood, "I was always more depressed." The second, participant

1258, similarly stated, “I used to be depressed and lonely.” Finally, the third, participant 2025, described her depression as a persistent state in her adolescence. She related the challenges she experienced at this stage in her life to “the depression that I had.” In sum, all three of these participants described their depression as chronic states they experienced in their lives.

Five participants did not elaborate on the transience of their depression, three (60%) in CD groups and two (40%) in NCD group. Thus, it is possible that more participants would have described their depression as transient or chronic if probed. Of the six participants who described their experiences as transient, four (67%) were in NCD groups and two (33%) in CD groups. Of the three who described their experiences as chronic, only one (33%) was in a CD group while the other two (67%) were in NCD groups. It is interesting that participants in CD groups would describe their experiences as transient because these individuals endorsed clinical levels of depression at all three time points.

Situational Depression. Of the eight participants who elaborated on the nature of their depression, seven stated (88%) that their experiences were triggered by a specific event or situation. Of these participants, five (71%) were in the NCD groups, while two (29%) were in the CD groups. For example, participant 1360, who was part of a CD group, described her depression as a direct result of her dysfunctional relationship with the father of her child. She explained:

Our relationship was always on and off. We’d get back together and we’d break up...It was always on and off, always on and off...The way that he treats me[,] **I’m always depressed because of him.** I feel like he doesn’t love his son, his family either. The way that he treats him.

Participant 1360 related her depression directly to the instability she experienced in her relationship with the father of her child, consistent with the major identifying feature of situational depression. Similarly, participant 2246, an NCD group member, connected her depression to the pressure she endured from her parents to drop out of high school while pregnant, and earn money to take care of her child. She reported:

I was really depressed and I wouldn't talk to anybody...because my parents would make me, every time I wanted to go to school, they would tell me that I needed to go work, that they wouldn't pay for anything.

Participant 2246 went so far as to insert the causal word “because” in her explanation of her experience, directly connecting her depression to the circumstances she was facing at the time. Participants who explicitly reported experiencing depression but did not describe the experience as “situational” either did not elaborate on the nature of their depression (6; 86%), or reported it as a disorder that they had independent of external circumstances (1; 14%). Indeed, the latter participant indicated that she had bipolar disorder as well as major depression, both of which precipitated a number of negative events in her life. She described:

I was an A, B student until I got to 9th grade. Once I hit 9th grade, it went all downhill...It was the bipolar moments that I had, the depression that I had, and at the same time, the losing my friends...I went from As, Bs to the end of 8th grade, I started with Cs Ds and Fs. They were like, ‘how did that happen?’

Unlike the other participants who described their depression as having been caused by the circumstances in their lives, participant 2050 reported the

inverse experience, with her depression and bipolar disorders triggering the decline of her academic performance and the general “downhill” trajectory of her life. Participant 2050 was the only one out of all thirty-six participants to explicitly describe her depression this way. Nevertheless, given the relatively high proportion of participants who did not elaborate on the nature of their depression (6; 43%), it is possible that others also viewed their depression as situational or otherwise, but did not explicitly state so.

Summary of Findings within Depression. Participants’ explicit reports of depression seemed to contain three themes namely *time frame*, where participants placed their experiences with depression in the past or the present; *transience*, where participants defined their depression as a transient, finite experience or a chronic state; and *situation-specificity*, where participants ascribed the nature of their depression to a specific event or situation in their lives, or described it as a generalized, non-context specific disorder. Perhaps because of the small number of participants who reported experiences with depression (14; 41%) and because not all participants described their depression within each of these specific themes, no salient patterns arose among the three themes in relation to one another.

Supports/Protective Factor(s). Participants in all four groups reported a number of protective factors across different domains of their lives. In order to analyze for patterns within and across groups, participants’ reported protective factors were organized into major themes, namely, *Family Support*; *Social Support*; *Education/Employment Opportunities*; *Stability in Relationship with*

Father of Baby (FOB)/Romantic Partner; Housing Stability; Good Immigration Experience; and Other. After the protective factors were organized into these seven themes and charts were constructed with participants' reports (see Appendix II for chart), no major thematic differences emerged within or between groups except in terms of *Social Support*. Particularly, almost twice as many participants in the NCD groups (13) reported sources of social support compared to participants in the CD groups (7). Within the theme of *Social Support*, the major difference between the two sets of groups seemed to lie in having a *supportive relationship with (a) best/close friend(s)*, reported by eleven NCD participants but only five CD participants.

Stressors/Risk Factor(s). Participants in all four groups also reported a variety of risk factors in different domains of their lives. These risk factors were organized into major themes, including *Familial Issues; Abuse; Issues with FOB/Romantic Partner; Issues with Social Relationships; Issues with Education/Employment; Issues with Immigration/Race/Ethnicity; Issues with Housing; Issues with Pregnancy/Child; and Other.* Once the risk factors were organized into these themes and charts were constructed with participants' reports (see Appendix III for chart), a few differences arose between the CD and NCD groups related to these themes. Particularly, more participants in CD groups reported risk factors related to *Issues with FOB/Romantic Partner* (10 NCD participants compared to 15 CD participants) and *Issues with Social Relationships* (2 NCD participants compared to 11 CD participants). Interestingly however,

more participants in NCD groups reported *Issues with Immigration/Race/Ethnicity* than participants in CD groups.

Within the theme of *Issues with FOB/Romantic Partner*, more participants from CD groups (10) reported the risk factor of having an *Inexistent or Conflictual Relationship with FOB* than participants from NCD groups (5). In terms of the theme *Issues with Social Relationships*, eight participants from CD groups reported having *Inexistent or Conflictual Relationship(s) with Peers (i.e., bullying)*, compared with only two participants from NCD groups. Within this same theme, 5 participants from CD groups reported having *Bad Interactions with Counselor(s)/Social Service Worker(s)* compared to no participants from NCD groups. Finally, as it relates to risk factors within *Issues with Immigration/Race/Ethnicity*, no particular concentration of reports occurred around any specific risk factors. Rather, more participants in NCD groups reported different types of risk factors within this theme than participants in CD groups.

Combination of Protective and Risk Factors. In addition to comparing the *types* of risk and protective factors that participants reported, *quantities* of these factors were also compared. Results from this analysis indicated that, on average, participants in CD groups experienced similar quantities of protective factors as participants in NCD groups, but much higher quantities of risk factors (see table below for details). An analysis of variance (ANOVA) of the quantities of risk and protective factors reported by participants showed that, while the difference between protective factors reported by participants in the NCD and the

CD groups was not statistically significant, the difference between the risk factors reported was statistically significant, ($F(1,31) = 36.933, p=.000$)

Table 1
Average risk and protective factors per group

	<u>NCD</u> <u>GROUPS</u>	<u>CD</u> <u>GROUPS</u>
Risk Factors	6	17
Protective Factors	8	8

Summary of Findings within Risk and Protective Factors. In terms of protective factors, *Social Support* emerged as a point of difference between the NCD and the CD groups, with more participants in NCD groups reporting sources of social support than participants in CD groups. As it relates to differences in risk factors, more participants in CD groups reported *Issues with FOB/Romantic Partner* (10 NCD participants compared to 15 CD participants) and *Issues with Social Relationships* (2 NCD participants compared to 11 CD participants). On the other hand, more participants in NCD groups reported *Issues with Immigration/Race/Ethnicity* than participants in CD groups. When the analysis was conducted in relation to quantities (ANOVAs), results indicated that the difference between the quantities of risk factors reported by participants in NCD and CD groups was statistically significant, while the difference in quantities of protective factors was not. This finding indicates that the ratio of risk to protective factors is higher for CD participants than it is for NCD participants.

Agency. Analysis was also conducted on texts coded in relation to participants' statements of *agency*. These statements were identified whenever participants referred to actions that they had taken to create change in their lives. For example, participant 2246 from the NCD/RIO group explained:

When I was seventeen, [my son] was four months or three and a half, and I moved here...Cause I had applied to college here, so I wanted to be settled before I'd move into that.

Earlier in the interview, she had mentioned that she was living with her mother and her mother's boyfriend in California, but that it was an unstable and often hostile environment. Participant 2246 then decided to move across the United States to New England after having her child so she could live with her father in a more stable situation and attend college. She demonstrated agency in making the move to improve her life.

In examining participants' statements of agency across groups, participants in NCD groups made, on average, more of these statements than participants in CD groups (see table below for details). An analysis of variance (ANOVA) of participants' statements of agency showed that the difference between these statements was statistically significant when comparing the CD and the NCD groups ($F(1,31) = 7.15, p=.012$).

Table 2

Average statements of agency per group

<u>NCD GROUPS</u>	<u>CD GROUPS</u>
13	7

Research Question #2

The second research question in this study stated, *Are there differences between the two groups of mothers in terms of how they use the Healthy Families program as well as more specific mental health services other than the home visiting program?* In order to answer this question, the codes *HFM Use* and *Mental Health Services* were used to identify relevant text within participants' interviews, the analysis of which texts revealed interesting patterns. More specifically, in terms of participants' utilization of Healthy Families services, it became clear that such utilization was related to participants' explicit reports of depression. Indeed, participants who explicitly spoke of having experiences with depression also tended to report having close relationships with their HVs. As it relates to the utilization of mental health services outside of Healthy Families, patterns that emerged were not related to explicit reports of depression, but rather to whether participants had a clinical diagnosis of depression. The following subsections present these patterns with examples from participants' narratives.

Utilization of Home Visiting Services. Because only participants in the NCD-HVS and CD-HVS groups had HVs, participants from the NCD-RIO and CD-RIO groups were not included in the analysis related specifically to Home Visiting Services. As a result, the latter groups are not discussed in this section.

NCD-HVS. Four (80%) of the five participants in the NCD-HVS group who mentioned having experienced depression also reported that they used their home visitor for emotional support, informal counseling, and/or referral services. The participant who did not use her HV for any of these supports had not met her

HV by the time of the first round of interviews. Thus, it is possible that she would have used her HV for these supports had they met and established a relationship prior to the interview. By contrast, the other four participants in the group who did not explicitly report any experiences with depression made no mention of receiving any kind of emotional support, informal counseling, and/or referral services from their HVs. Rather, their relationships with their HV seemed formal and even minimal in some cases. For example, describing her interactions with her HV, participant 1079 explained:

1079: I didn't really know her...she only came a couple times...dropped off paperwork, and just...she would read it off to me and then pretty much leave...She really didn't talk much.

I: Ok, so do you feel like you didn't really have a relationship, or...?

1079: Yeah, I don't think we really had one.

As she explains, participant 1079 was never able to develop any kind of relationship with her HV. The following sections describe the types of support received by participants who reported having close relationships with their HV.

Emotional support. Four (80%) of the five participants who explicitly reported experiences with depression described their relationships with their HVs as emotionally supportive, whereby HVs provided participants with active listening, empathy, and trustworthiness, among other features. For example, 1055 reported about her HV:

She was very open...and she understood me...and we was just...we was like friends...I could tell her anything.. and I know she'd keep it to herself...and she helped me out with my problems, and made sure I do what I have to do...she's like a friend that I could hang out with, and have fun...she's very nice, understanding, funny, and she's great to hang out with

1055's account of her relationship with her HV demonstrated a connection between the two of them, where 1055 felt as though she could trust her HV and rely on her to help her deal with her problems. Similarly, participant 1487 felt as though her HV were part of her family, and was someone who would keep her company and give her advice whenever she needed it. Describing the type of support that she received from her HV, she explained:

I would say advice, and sometimes company, because being a mom, sometimes you lose contact with lots of your friends... So she comes - seeing her come, actually being home on my day off and knowing that somebody's going to come see me with the baby, it feels good. I'm going to have company for about an hour... Sometimes even longer if she hangs out, we eat or something...

She plays a big role, I kind of feel like she's [baby's name]'s... aunt or something... She's part of the family, that I can't deny 'cause his first birthday party she's going to be - she went to the hospital when he was born, and I wouldn't think she would do that, but when I called to tell her that he was born, she was, I already got the gift, I'm on my way already. It wasn't major or anything like that, but just the thought counts. And then the fact that she just - I just couldn't, I actually hugged her and my eyes got watery 'cause we've been waiting for her for so long and then, every single time I was in the hospital, she was involved, she knew everything even before I told her because she had all my doctor's records and she could get into my doctor information.

As participant 1487 explained, she came to rely on the emotional support that she received from her HV, and valued it to the extent that she considered her HV to be part of her family. She later explained that her HV was someone whom she would call whenever she needed someone to talk to, and felt as though she could always trust her HV to be there for her. She described:

I know I can call her and leave her a message, like oh, I'm having a really bad day or this happened, I need some advice or can you give me a call back, I need to talk with somebody and she's willing to call me when she gets a chance. Even sometimes when she's on lunch she'll call me and be like, what's going on and I tell her, you know, this happened with the baby's father. What do I do now? And she helps me out.

As the excerpt shows, participant 1487 relied on her HV for emotional support whenever she was facing challenges in her life. Similarly, participant 1065 described her HV as a friend who was always there to advise her and be a friend:

1065: She gives me moral support if I have problems... I can talk to her.
Interviewer: Could you tell me which is the most important kind of help that she gives you?

1065: I think that when she talks to me or gives me advice...She's my friend...She's a very good person...She's caring with my baby. She's always very cheerful when she's talking to me... She's very sweet.

In sum, four (80%) of the five participants in the NCD-HVS group who explicitly reported that they experienced depression also described their relationship with their HV as emotionally supportive.

Informal counseling. In addition to emotional support, participants in the NCD-HVS group also reported using their HV for services akin to counseling. Indeed, participant 1087 gave an example of a time when her HV helped her through the issues she was having with her mother:

One of the times that she came here, I was...me and my mom were kind of fighting, and I got so mad that I filled out a form for Section 8, and then after I told my mom that, we talked about it, and I guess kind of fixed things again.

Interviewer: Ok, and your HV helped you how?

1087: She told me that things...she goes, 'It's probably just a little fight, things will get better, don't stress about it.'

Participant 1087's HV gave her guidance on how to handle a difficult situation with her mother, rendering this support analogous to counseling.

Likewise, participant 1487 described her HV's support throughout her relationship with the father of her child:

P: She impacted a lot on the way we went about breaking up. You know, she said do it as civilized as possible and stay friends for the baby also. We did come across a couple problems. I had to get a restraining order and all that stuff and [HV's name], she helped me figure out how to do it in a way that it was going to be good for the baby, so now our relationship's strong a lot because of her, she's interfered a couple times. We've even had times where he's there, I'm there, and she's there and we talk.

As these examples illustrate, participants' HVs provided them with significant support in resolving their personal problems, a function similar to services provided by a counselor. Indeed, participant 1065 explicitly referred to her HV as a counselor:

Interviewer: Ok. And how, you already told me how she's like a friend. Now, thinking about the friends that you already have, how does she compare to your friends?

1065: **I think that it's different because she's also like, so talking with her is as if I were talking [to] some of those, what are they called? Counselors?...**it's like talking with them because...they always know what to say to you, when there are problems, what to say to you...Girlfriends sometimes...Sometimes they don't know what to say.

As 1065 explained, she felt that her HV always knew how to advise her through her personal problems, a feature of their relationship that was different from her relationships with her girlfriends, making her HV appear similar to a counselor.

Referral services. In addition to using their HVs for informal counseling, participants in the NCD-HVS group also used their HVs for referrals to formal mental health counseling. Participant 1055, for example, explained that her HV would connect her with therapeutic services if needed:

Interviewer: Can you think of three things that HF the program has helped

you with?

1055: Being a mother. Supporting me on tough stuff, providing clothes.

Interviewer: Ok, so when you say helping you be a mother, what does that entail?

1055: They give me pamphlets and talk to me about how to raise a kid.

Interviewer: Mhm, and then you said the second one was support about tough stuff?

1055: Like if I have issues. Like an example, I'm in depression...So if they made me go to some...made me make an appointment with a therapist, they'd help me.

Participant 1487 also described the referral that she received from her HV to receive counseling for her and her boyfriend. She described:

We had an argument once and we were thinking separating or whatever, and she said oh, counseling would help and stuff like that, or just anger management class, and we did it for I think it's been 3, 6 months or so, and we've been great, she gave me that.

In sum, participants in the NCD-HVS group who experienced depression also tended to utilize their HV for emotional support, informal counseling, and/or referral services. This pattern suggests that these participants may be more likely to seek these supports when experiencing, or after having experienced, psychological issues in the past.

CD-HVS. Both participants (100%) who mentioned an experience with depression also reported receiving emotional support from their HVs. However, unlike participants in the NCD-HVS group, neither participant in CD-HVS reported receiving referral services from their HVs, and only one reported receiving informal counseling. Notably, however, the six participants (75%) who did not explicitly report any experiences with depression also did not report receiving any emotional support, informal counseling, or referrals from their HVs.

The following two sections describe participants' experiences with receiving emotional support and informal counseling from their HVs.

Emotional support. Participants' reports of the emotional support they received from their HVs included advice-giving as well as a friend-like connection. To these participants, their HVs were more than workers who came to their homes to fulfill the requirements of a job. For example, in an exchange with the interviewer, participant 1258 explained:

I: If you had to describe her to me...like...who she is [or] what was she like?

1258: / She was nice, yeah. she was just nice, she'd talk to me, give me a bit of advice...She was kinda young, she had kids young like me...And I got comfortable talking to her...

I: Ok and then when you think back to [HV], what type of role did you see her playing in your life? What type of role was she? Like what kind of person was she to you?

1258: She was like a friend.

Participant 1258 described her relationship with her HV as a friendship, with her HV being someone with whom she felt comfortable talking and who would give her advice. Participant 1360 alluded to similar features in her relationship with her HV as participant 1258. She explained:

1360: I could tell her my feelings and she would not tell anybody else.

I: So you can trust her?

1360: Yeah...

I: So you said she's like a friend?

1360: Yeah

I: How is she like your other friends?

1360: Well I never had close friends cuz I'm not, I'm just a girl that doesn't like being with people. I'm always by myself. Yeah, I have friends, but I don't care about them. I do care about them if something happens but I'm not/ really close...

I: / Not really close? So would you say that you talk to her more than you talk to them?

1360: Yeah

In participant 1360's own words, she felt more comfortable talking to the HV than with her own friends. Her HV provided her with emotional support that she seemed to not receive from anyone else in her life.

Informal counseling. In addition to receiving emotional support, participant 1360 also received informal counseling from her HV, particularly at times when she felt very depressed and was having difficulty dealing with her child. She explained:

1360: I'll call her and I'll tell her what's going on. She'll give me advice and tell me to calm down. She used to tell me how to calm down. I need to go outside. When he starts crying and is like that, just to leave. Put him in his crib and leave outside and just take a deep breath.

I: A moment to yourself.

1360: Yeah

I: So when you are depressed and you cancel appointments, does she know? She tells you maybe we should still meet?

1360: Yeah, she does that.

I: Sometimes, does she reschedule with you?

1360: Mhm

I: So even though you've had moments like that, you're still in the program because she still tries?

1360: Yeah. It's just.... When we saw each other, we just clicked. She was like one of our family members because she's so nice.

I: So you got along really well and everything?

1360: Mhm

Participant 1360 felt that her HV could counsel her through challenging moments with her child and help her to continue on with her obligations.

However, she was the only one in this group who seemed to have received this kind of support from her relationship with her HV.

Summary of Findings within Home Visiting Services. Participants who reported that they were experiencing or had experienced depression also reported that they had received emotional support, informal counseling, and/or referral

services from their HVs. Interestingly, participants who did not report such experiences with depression also did not report receiving these kinds of supports from their HVs. Rather, their relationships with her HVs seemed to be more superficial and formal.

Utilization of Mental Health Services. From the overall sample of thirty-four participants, ten (29%) explicitly reported using mental health services (i.e., therapy, counseling). Of these participants, a greater amount was in CD groups (7; 70%) compared to NCD groups (3; 30%). This is a logical finding given that CD participants reported clinically elevated levels of depression at all three time points. However, it is notable that most of these participants (5; 50%) reported using mental health services in the past and no longer using them at the time of their interviews.

Chapter 5: Discussion

As discussed above, participants' narratives yielded several key patterns. The first set of these patterns related to participants' explicit reports of depression, as well as the particular ways in which they reported these experiences, which in turn included aspects of *time frame*, *transience*, and *situation-specificity*. This chapter begins by discussing the relevance of these findings.

Participants' Descriptions of Depression

Of the thirty-four participants in the overall sample for this study, fourteen explicitly mentioned that they had experienced, or were currently experiencing depression. Of these participants, eight were in NCD groups and six were in CD groups. The distribution of these participants presents an interesting point,

particularly insofar as only six participants in CD groups made any mention of experiencing depression, though all sixteen participants in these groups had chronically elevated levels of depression at all three time points. At least one major factor may be associated with the fact that ten clinically depressed participants made no mention of their depression, namely that of *mental health stigma* (Hinshaw, 2005; U.S. Department of Health & Human Services, 2001). This term refers to “the extent to which individuals are concerned about how they or others negatively perceive those who seek mental health services” (Turner, Jensen-Doss, & Heffer, 2015, p. 2). Hispanic communities have been found to endorse significant mental health stigma, often preventing individuals in these communities from attributing psychological or emotional issues to mental illness, and from seeking appropriate services to address these issues. Thus, it is possible that participants in this study who did not discuss their depression despite having consistently elevated levels of the disorder may have been reflecting internalized mental health stigma. However, because stigma was not addressed in this study or during participants’ interviews for the larger MHFE study, further research is warranted to examine the extent to which stigma prevents the spontaneous discussion of depression among Hispanic teen mothers.

Participants’ spontaneous reports of depression or lack thereof raise further questions. Namely, because interviewers asked similar questions of all participants, what factors other than stigma could have motivated some participants to disclose their depression and others to not do so? Are there particular characteristics, such as individuals’ ethnic heritage, acculturation level,

immigration status, level of education, socioeconomic status, developmental stage, among others, that influence their likelihood of deliberately discussing their depression? Moreover, are participants who discuss their depression without being prompted to do so more likely to be open to, to access or to have accessed, mental health services? The answers to these questions would provide further clues into understanding mental illness within the understudied population of Hispanic teen mothers.

Regarding the themes that emerged from the analysis of depression, *time-frame* was important particularly because two participants in non-clinically depressed (NCD) groups reported that they were currently depressed and three participants in clinically depressed (CD) groups reported that they were no longer depressed. Though these differences are certainly small, these reports nevertheless present a potential discrepancy because at all three time points, participants in CD groups had clinically elevated levels of depression, while participants in NCD groups had levels well below the cut off for clinical elevation (>13). At least one major factor may account for this discrepancy, namely that the CES-D scale may not always accurately measure depression in Hispanic adolescent mothers. For example, Perreira, Deeb-Sossa, Harris, and Bollen (2005) note that different studies have reported inconsistent rates of depression among ethnic groups of adolescents as measured by commonly used depression instruments, including the CES-D scale. The authors posit that these inconsistencies may occur because these instruments might not accurately measure depression within each group. Indeed, scores may be biased not because each group has more or less depressive

symptoms, but because psychopathology might be expressed differently from the Westernized view of the concept that is adopted by each measure (Perreira et al., 2005; Vega & Rumbaut, 1991).

As it relates to Hispanic populations in particular, depression symptomatology has been found to prominently feature *somatization*, or physical symptomatology without medical cause (Angel & Guarnaccia, 1989; Finch, 2002). In a factor analysis of the CES-D scale for Mexican-Americans, Cuban-Americans, and Puerto Ricans, Guarnaccia, Angel, and Worobey (1989) found that the scale's four-factor structure (including depressed, positive, somatic, and interpersonal) was rejected for all three groups at high levels of significance. Instead, a three factor structure emerged consistently across all three groups where a combined affective and somatic factor accounted for greatest variance (Guarnaccia, Angel, & Worobey, 1989). Somatization might occur for different reasons including the aforementioned cultural stigma associated with seeking mental health services. More specifically, individuals in these populations may feel ashamed of their psychological/emotional challenges and may seek a primary care provider instead of a mental health professional. In such cases, they might express their symptoms more somatically in order to gain the care they need but not receive a psychopathological diagnosis (Perreira et al., 2005). Thus, because of the potential diagnostic inaccuracy of the CES-D scale, it is possible that depression was not accurately measured in the sample for the study presented in this paper.

The subthemes of *transience* and *situation-specific* depression may also be consistent with previous research on depression in Hispanic populations.

Particularly, it may be the case that these features are associated with the culturally-bounded disorder of *nervios*, where a culturally-bounded disorder is a “localized, folk, diagnostic categor[y] that frame[s] coherent meanings for certain repetitive, patterns, and troubling sets of experiences and observations”

(American Psychiatric Association, 2000, p. 898). *Nervios* is a folk idiom used among Hispanics that signifies transient psychological distress associated with significant stress from environmental circumstances, and encompasses symptoms of crying, difficulty sleeping, shaking or trembling, sadness, being easy to anger, and hopelessness (APA, 2005; Guarnaccia, Lewis-Fernandez, & Rivera Marano, 2003; Paniagua & Yamada, 2013; Weller et al., 2008) – all of which have strong associations with depressive symptoms ($p < 0.00$; Weller, Baer, Garcia de Alba Garcia, & Rocha, 2008). Thus, when participants in this study described their experiences with depression as transient and situational, they may have been conveying their depression as the culturally-bound syndrome of *nervios*.

Nevertheless, few studies have explored the types of depression most prevalent among Hispanic populations, and none appear to have done so for Hispanic teen mothers. Therefore, the high relative quantity of reported *transient* and *situational* depression in this study cannot be compared to extant literature. This is a crucial point because there are eight different types of depression identified in the DSM-5 based on symptomatology, length, and severity, and each type may benefit from distinct (though sometimes overlapping) treatment

methods (Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, 2013; National Institute of Mental Health, 2011). As a result, the dearth of knowledge regarding the depressive typology most prominent in Hispanic populations may be a disservice to the diagnosis and treatment of these individuals.

Risk and Protective Factors

Findings from this study indicated that more participants in NCD groups than in CD groups reported protective factors related to social support, specifically in terms of having a supportive relationship with (a) close or “best” friend(s). More participants in NCD groups also reported having issues with immigration, race, and/or ethnicity. On the other hand, more participants in CD groups reported having inexistent or conflictual relationships with the father of their children and with peers, as well as bad interactions with counselors and/or social service workers.

Studies on the relationship between peer support and well-being among teen mothers have shown mixed results. Some studies have shown no significant relationship between the two factors (Sgarbossa & Ford-Gilboe, 2004), while others have found that higher levels of peer support are associated with higher indices of psychological distress (Thompson, 1986; Thompson & Peebles-Wilkins, 1992). Other studies yet have shown peer support to be positively correlated with well-being and quality of life in teen mothers (Kissman & Shapiro, 1990; Richardson, Barbour, & Bubenzer, 1995). Due to the inconsistent findings regarding peer support and the well-being of teen mothers, as well as the

lack of studies focused specifically on peer support as a protective factor against depression in Hispanic teen mothers, further research is needed to explore this relationship.

Conversely, conflict in romantic relationships and among peers has shown to predict depressive symptoms among adolescents, including those of Hispanic ethnicity (La Greca & Harisson, 2005). Specifically in terms of having a romantic relationship with the FOB, adolescent mothers often cite problems including unmet expectations for financial and child care assistance, tumultuous breakups, and physical and sexual assault. These problems have been associated with elevated depression among adolescent mothers, and have been shown to be consistent across Hispanic adolescent mothers as well (Gee & Rhodes, 1999; Gee & Rhodes, 2003). Therefore, the fact that more CD participants reported conflictual relationships with peers and FOBs is consistent with much of the literature on this topic.

More CD participants in this study also reported the risk factor of having negative interactions with counselors and social service workers. This finding is consistent with the previous discussion in this paper related to the lack of respect and stigma that adolescent mothers often perceive from clinicians and other professionals with whom they come into contact (Horowitz, 1995; Silver, 2008; Brubaker, 2007; Fessler, 2008). In the context of these interactions, mothers have reported feeling resentment, fear, shame, anger, and worthlessness, all of which closely mirror symptoms of depression. Thus, raising awareness among professionals that frequently deal with teen mothers may be an important avenue

through which to reduce depressive symptoms among this population. However, further research is needed to explore how negative interactions with professionals affect Hispanic teen mothers in particular.

Finally, this study found a statistically significant difference between the quantity of risk factors reported by participants in CD groups and that reported by participants in NCD groups, but no statistically significant difference between the quantity of protective factors reported by the same individuals. This finding suggests that the ratio of risk to protective factors was higher for CD participants than for NCD participants, consonant with the Risk and Resilience framework (Jenson & Fraser, 2006) that undergirded this project's theoretical basis. Particularly, this framework posits that resilience arises when protective factors provide sufficient buffering from risk. Conversely, where there is cumulative risk and insufficient buffering, adverse outcomes are more likely to occur. According to this theory, then, it is logical that participants who exhibited the adverse outcome of depression in this study would report a higher ratio of risk to protective factors.

Agency

This study also found a statistically significant difference between the amount of statements of agency made by participants in NCD and CD groups. Extant research has found that low levels of agency may influence the onset of depression through passive, unassertive, and submissive behaviors, among others (Nolen-Hoeksema, 1995), rendering this finding logical and consistent. However, the prevalence of agency among Hispanic populations is far less studied, and as a

result, it is unclear whether demonstrating agency is adaptive in these often more collectivistic cultures (Hofstede, Hofstede, & Minkov, 1997). Therefore, more research is needed on this topic.

Research Question #2

Utilization of Home Visiting Services. HVS participants who explicitly reported that they had experienced depression also tended to report having deeper relationships with their HVs, with particular features of these relationships including emotional support, informal counseling, and referrals to other relevant services. This finding may be consistent with other research suggesting that Hispanic individuals are more likely to seek informal sources of mental health care (Cabassa & Zayas, 2007). Indeed, given the more informal and in-home nature of home visiting, participants may see their HVs as alternatives to other professionals, and may foster relationships with their HVs through which they can attain the help that they need. If so, it may be the case that home visiting is a more culturally appropriate way to provide for the needs of Hispanic teen mothers than other types of services. Home visiting may be especially appropriate for individuals experiencing the culturally-bound syndrome of *nervios*. Given the syndrome's situational and transient nature, home visiting services may provide the immediate and concentrated support that these individuals may need in addressing their symptoms. However, more research is needed to investigate the features of home visiting, as well as the characteristics of home visitors as individuals (i.e., age, ethnic heritage, etc.), that may be more appealing to this population.

Nevertheless, it may also be the case that participants who were more likely to spontaneously report experiences with depression were more open and more willing to share the circumstances of their lives. If so, they may be more likely to develop deeper, more meaningful relationships with their HVs. Hence, more research is also needed to explore the characteristics of individuals who derive the most benefit from their relationships with their HVs.

Utilization of Mental Health Services. Of the ten participants who reported using mental health services, seven were in CD groups and three were in NCD groups. Moreover, most of these ten participants reported using mental health services in the past and no longer using them at the time of their interviews. Because participants were not asked explicitly about their utilization of mental health services during their qualitative interviews, little can be said about whether CD participants in general were seeking the services they needed. However, the fact that most CD participants who reported that they had received mental health services were no longer receiving such services is consistent with research showing that Hispanic individuals are more likely to discontinue services before achieving therapeutic goals (Barona & Barona, 2003). It was also explained earlier that seven of the eight participants who described the nature of their depression perceived it as the result of the circumstances in their lives. Therefore, it may be the case that individuals who see their depression as situational may stop going to therapy once the stressful circumstance(s) has/have subsided. Further research is needed to examine the link between one's perception of her depression and her likelihood of seeking, and remaining in, therapy.

Limitations

This study contained a number of limitations. First, given the selection criteria, only thirty-four participants were included in the sample, restricting this author's ability to draw conclusions about patterns that arose, and diminishing the possibility of generalizability. Furthermore, the protocol utilized for qualitative interviews did not include explicit questions about participants' experiences with depression, risk and protective factors, and mental health services. As a result, analyses relied on participants' spontaneous discussion of these topics. In addition, participants' Hispanic heritage was not considered during analyses, though "Hispanic" ethnicity encompasses a number of heterogeneous populations. Therefore, findings might have been different if ethnic heritage were taken into consideration.

This study contained further limitations related to the measurement of depression and linguistic issues. Particularly, and as previously discussed, the CES-D scale may not be a valid instrument for measuring depression among Hispanic teen mothers, such that the stipulation of which participants in this study were depressed and which were not based on this measure may have been inaccurate. Moreover, the study relied heavily on participants' spoken (during qualitative interviews) and written (for quantitative measures) reports of their experiences. However, all participants identified themselves as *Hispanic*, meaning that many of them may speak Spanish as their first language and English as their second. For participants whose first language was Spanish and who decided to conduct their interviews in English, certain information may have been conveyed

inaccurately due to linguistic challenges. Conversely, for participants whose first language was Spanish and who decided to conduct their interviews in Spanish, errors could have occurred during the translation of research materials. In either case, reports used in this study may not fully convey the meaning that participants intended to put forth when supplying information to interviewers.

Chapter 6: Conclusion

Despite its significant limitations, this study nevertheless found several crucial areas for further research. In terms of the first research question, the depression theme of *time frame* indicated the possibility that the CES-D scale does not accurately measure depression in Hispanic teen mothers. Indeed, somatization is found to be the most prominent feature of depression in Hispanic populations (Angel & Guarnaccia, 1989; Finch, 2002), yet the CES-D scale does not account for the variance posed by this symptom within these populations (Guarnaccia, Angel, & Worobey, 1989). In turn, the depression themes of *transience* and *situation-specificity* may be related to the common perception of depression in Hispanic populations as the culturally-bounded disorder of *nervios* (APA, 2005; Guarnaccia, Lewis-Fernandez, & Rivera Marano, 2003; Paniagua & Yamada, 2013; Weller et al., 2008). Therefore, further research is needed to investigate the psychometrics of the CES-D scale for Hispanic teen mothers, as well as the perception, and most common types, of depression within this population.

In terms of risk and protective factors, it was found that support or conflict in peer and romantic relationships, as well as negative interactions with social

service professionals, may influence the course of Hispanic teen mothers' depression. Future research should be conducted to elucidate the extent to which these factors contribute to the onset or the aggravation of depression in this population. Consistent with a Risk and Resilience framework, it was also found that CD participants reported a higher ratio of risk to protective factors compared to NCD participants. Thus, a potential avenue of intervention for this population is diminishing the quantity of risk factors to which they are exposed, and/or enhancing their protective factors. Finally, NCD participants reported greater agency than CD participants. Though this finding is promising in terms of preventing the development of depression in this population, further research is needed to understand whether the promotion of agency is congruent with the collectivist values of Hispanic populations (Hofstede, Hofstede, & Minkov, 1997).

In terms of the second research question, it was found that participants who explicitly reported having depression described having deeper, more intimate relationships with their HVs. In light of other research indicating that Hispanics are more likely to seek informal sources of mental health care, it is possible that home visiting and other more informal services are more culturally appropriate ways to reach these populations. Moreover, more CD than NCD participants reported using mental health services, but most of these participants had used and ended these services in the past. In relation to many participants in this study viewing their depression as situational, it may be the case that perceiving one's depression as situational means that one terminates mental health services once

the stressful situation(s) has subsided. Thus, it is important to understand the relationship between one's perception of her depression and the likelihood of seeking, and remaining in, therapy.

In sum, the findings in this study revealed several areas that warrant further research within the largely understudied population of Hispanic teen mothers (Koleva & Stuart, 2014). If taken up, these areas of research have the potential of significantly improving outcomes not only for these young women but also their children.

Appendix I

Table 3

Descriptives of Total Sample (N=34)

	<u>Total</u>	<u>NCD-HVS</u>	<u>NCD-RIO</u>	<u>CD-HVS</u>	<u>CD-RIO</u>
Self-Reported Heritage					
Colombia	<u>2</u>	<u>1</u>	<u>1</u>	<u>0</u>	<u>0</u>
Dominican Republic	<u>5</u>	<u>1</u>	<u>0</u>	<u>2</u>	<u>2</u>
Ecuador	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u>
El Salvador	<u>3</u>	<u>1</u>	<u>1</u>	<u>1</u>	<u>0</u>
Guatemala	<u>1</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>
Honduras	<u>1</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>
Mexico	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>	<u>1</u>
Puerto Rico	<u>19</u>	<u>3</u>	<u>7</u>	<u>5</u>	<u>4</u>
Puerto Rico + Dominican Republic	<u>1</u>	<u>1</u>	<u>0</u>	<u>0</u>	<u>0</u>
Place of Birth					
U.S. (mainland and territories)	<u>27</u>	<u>6</u>	<u>7</u>	<u>7</u>	<u>7</u>
Outside the US	<u>7</u>	<u>3</u>	<u>2</u>	<u>1</u>	<u>1</u>
CES-D Average Scores					
T1	<u>16.56</u>	<u>7.89</u>	<u>4.78</u>	<u>27.75</u>	<u>28.38</u>
T2	<u>14.71</u>	<u>6.11</u>	<u>5.56</u>	<u>22.75</u>	<u>26.63</u>
T3	<u>13.88</u>	<u>5.00</u>	<u>6.78</u>	<u>23.50</u>	<u>22.25</u>

Appendix II

Table 4

Themes in Protective Factors

	<u>NCD/HVS</u>	<u>NCD/RIO</u>	<u>NCD</u> compared to CD	<u>CD/HVS</u>	<u>CD/RIO</u>
Family Support	1055, 1130, 1079, 1049, 1087, 1065, 1112, 1022, 1487 (9)	2050, 2002, 2246, 2274, 2165, 2025, 2145, 2173, 2221 (9)	18/14	1193, 1477, 1494, 1102, 1360, 1204 (6)	2103, 2153, 2259, 2294, 2020, 2251, 2194, 2237 (8)
Social Support	1055, 1487, 1130, 1065, 1022, 1079, 1049 (7)	2025, 2050, 2145, 2246, 2173, 2165 (6)	13/7	1477, 1494 (2)	2020, 2194, 2294, 2237, 2251(5)
Education/Employment	1087, 1130, 1487, 1079, 1112, 1022, 1049 (7)	2002, 2246, 2221, 2050, 2165, 2145, 2173, 2274 (8)	15/16	1102, 1204, 1258, 1494, 1360, 1102, 1477, 1258 (8)	2194, 2251, 2294, 2259, 2103, 2153, 2020, 2237 (8)
FOB/Romantic Partner	1087, 1487, 1065, 1022, 1049, 1079, 1112 (7)	2050, 2145, 2246, 2165, 2173, 2221, 2025, 2274 (8)	15/10	1477, 1360, 1494, 1102, 1204 (5)	2020, 2153, 2237, 2259, 2194 (5)
Housing Stability	1487, 1079 (2)	2274 (1)	3/5	1204 (1)	2153, 2194, 2237, 2251 (4)
Positive Immigration Experience		2246 (1)	1/0		
Other		2025, 2246, 2173 (3)	3/5	1193, 1360 (2)	2251, 2194, 2259 (3)

Appendix III

Table 5

Themes in Risk Factors

	<u>NCD/HVS</u>	<u>NCD/RIO</u>	<u>NCD</u> <u>compared</u> <u>to CD</u>	<u>CD/HVS</u>	<u>CD/RIO</u>
Familial Issues	1087, 1487, 1130, 1022, 1079, 1112, 1065 (8)	2050, 2025, 2002, 2246, 2173, 2146, 2165 (7)	15/15	1204, 1477, 1193, 1258, 1494, 1102, 1360 (7)	2194, 2251, 2103, 2020, 2153, 2294, 2259, (8)
Abuse	1130, 1112, 1065 (3)	2173, 2025, 2165 (3)	6/8	1193, 1258, 1204 (3)	2103, 2251, 2194, 2294, 2259 (5)
Issues with FOB/Romantic Partner	1055, 1487, 1112, 1130, 1049, 1079 (6)	2146, 2221, 2050, 2165 (4)	10/ 15	1193, 1258, 1494, 1360, 1204, 1477, 1102 (7)	2020, 2103, 2194, 2237, 2251, 2294, 2259, 2153 (8)
Issues with Social Relationships	1087, 1112 (2)		2/11	1193, 1258, 1494, 1102, 1204, 1360 (6)	2103, 2153, 2237, 2259, 2251 (5)
Issues with Education/Employment	1055, 1087, 1130, 1065, 1022, 1079, 1049, 1487 (8)	2025, 2002, 2165, 2173 (5)	13/15	1193, 1477, 1360, 1204, 1258, 1494, 1102 (7)	2103, 2153, 2194, 2237, 2259, 2294, 2251, 2020 (8)
Issues with Immigration/Race/Ethnicity	1130, 1065, 1022, 1112, 1049 (5)	2173, 2145 (2)	7/2	1204, 1258 (2)	
Issues with Housing	1130, 1079,	2173, 2274,	7/8	1193, 1477,	2103, 2194,

	1112 (3)	2165, 2145 (4)		1360, 1204 (4)	2251, 2259 (4)
Issues with Pregnancy/Child	1087, 1487, 1065 (3)	2025 (1)	4/8	1204, 1360, 1193, 1477 (4)	2194, 2103, 2251, 2294 (4)
Other	1130, 1065, 1022 (3)	2145, 2025 (2)	5/10	1204, 1494, 1260, 1102, 1258 (5)	2259, 2020, 2103, 2194, 2237 (5)

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