A Qualitative Study of Maternal Depression in the Latina Community: Contributors and Barriers to Identification and Treatment

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Abstract
Depression significantly and negatively impacts individuals, families, and communities. Yet, how it impacts individuals and communities varies across gender and culture. Latinas, one of the fastest growing populations in the US, experience higher rates of depression, but they are not adequately treated. Given the high birth rates among Latinas, along with the adverse developmental outcomes experienced by children with a depressed mother, understanding the higher rates of maternal depression and identifying barriers to treatment are imperative to improving care for Latinas. Two factors that may contribute to Latinas’ experience of depression are acculturation and mental health stigma. Specifically, these factors may keep Latinas from identifying "Western" or criteria specific symptoms or believing it is acceptable to acknowledge depression. Additionally, mental health stigma often leads to avoidance of treatment seeking due to associated ideals (e.g. medication as addictive, thinking one is “loca”) and fear of others finding out. While studies have looked at maternal depression among Latinas on a larger scale, few have examined maternal depression and barriers to treatment from a community perspective geared toward service providers who may be able to speak to the contextual factors not captured in large scale quantitative studies. Given the current social and political climate – including changing immigration policies, Immigration and Customs Enforcement (ICE) raids, hateful rhetoric, and increased racial tensions - it is imperative to understand the experience of maternal depression and related barriers to identification and treatment among Latina mothers. This study uniquely uses a qualitative design including interviews with key stakeholders in the community to capture perspectives on rates of depression, the role of acculturation status, and influential aspects of mental health stigma on the experience of maternal depression among Latinas in western Oregon.

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A QUALITATIVE STUDY OF MATERNAL DEPRESSION IN THE LATINA COMMUNITY: CONTRIBUTORS AND BARRIERS TO IDENTIFICATION AND TREATMENT

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Potential contributing factors and barrier to the experience of maternal depression in the Latina community

Dissertation directed by Theresa Lafavor, Ph.D.

Abstract

Depression significantly and negatively impacts individuals, families, and communities. Yet, how it impacts individuals and communities varies across gender and culture. Latinas, one of the fastest growing populations in the US, experience higher rates of depression, but they are not adequately treated. Given the high birth rates among Latinas, along with the adverse developmental outcomes experienced by children with a depressed mother, understanding the higher rates of maternal depression and identifying barriers to treatment are imperative to improving care for Latinas. Two factors that may contribute to Latinas’ experience of depression are acculturation and mental health stigma. Specifically, these factors may keep Latinas from identifying “Western” or criteria specific symptoms or believing it is acceptable to acknowledge depression. Additionally, mental health stigma often leads to avoidance of treatment seeking due to associated ideals (e.g. medication as addictive, thinking one is “loca”) and fear of others finding out. While studies have looked at maternal depression among Latinas on a larger scale, few have examined maternal depression and barriers to treatment from a community perspective geared toward service providers who may be able to speak to the contextual factors not captured in large scale quantitative studies. Given the current social and political climate – including changing immigration policies, Immigration and Customs Enforcement (ICE) raids, hateful rhetoric, and increased racial tensions - it is imperative to
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Keywords: Latina, Hispanic, Maternal Depression, Stigma, Acculturation, Barriers to Care

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The Hispanic/Latino population is the fastest growing population in the United States (US Census). According to recent census data, there are 55 million Latino/Hispanic people (17% of the U.S. population) living in the U.S. making them the nation’s largest ethnic or racial minority. Sixty-four percent of Latino/Hispanic people in the U.S. are of Mexican origin (US Census) and 11.3 million of whom are unauthorized immigrants (Krogstad & Passel, 2015).

From 2013 to 2014, 1.15 million Latino/Hispanic people were added (through immigration and recent births) to the nation’s population – roughly half the approximately 2.36 million people added to the total U.S. population during this period (US Census, 2015). Additionally, reports indicate 38.4 million U.S. residents age 5 years or older spoke Spanish at home in 2013, which accounts for 73.3% of the Latino/Hispanic population. However, it’s not the sheer size of this growing population that makes this group significant, but also their experiences. According to recent statistics, 23.5% of Latino/Hispanics live in poverty, 24.3% lack health insurance (U.S. Census), and 15.6% experience mental illness (SAHMHSA). The startling reality that roughly one quarter of our nation’s largest minority population faces severe adversity is deeply concerning. Adding to these already startling statistics, Latinas face higher rates of depression and lower rates of treatment than their non-Latina counterparts (Golding, 1990; Logsdon et al., 2018; Oliveira et al., 2017; Pincay, 2007). However, the reported rates of depression vary across studies with some research suggesting rates of depression among Latinas are comparable to other groups (Ishakawa, 2014), and others stating the increased rates occur in the most vulnerable populations: the unemployed, those living in poverty, those with less than a high school education, and monolingual Spanish speaking populations (Caplan & Whittemore, 2013).

Despite the mixed results regarding the prevalence of depression among Latinas, research suggests Latina mothers face contextual factors that put them at disproportionate risk for
experiencing depression, which is the number one non-fatal disease burden worldwide (Lopez, Mathers, Ezzati, Jamison, & Murray, 2006). Given Latinas have the highest birth rates of any ethnic group, and maternal depression has been continuously linked with adverse child outcomes (Anderson & Hammen, 1993; Ashman, Dawson, & Panagiotides, 2008), it is imperative to understand the experience of maternal depression among these women.

One of the difficulties in examining Latinas’ experience of maternal depression is there may be other factors that contribute to the experience of depression and lack of treatment, including acculturation and mental health stigma. Cultural factors such as language, values, and norms may keep Latinas from identifying depression as identified by western definitions (i.e. symptom criteria) and/or feeling comfortable seeking treatment from people outside their culture and community. Additionally, mental health stigma may prove to be a significant barrier for these women as research has shown stigma can lead to negative ideas about those with mental health issues, which in turn can cause someone to hide their own mental health concerns and symptoms (Bharadwaj, 2017). However, measuring these experiences and potential barriers can be difficult using broad based quantitative measures, as many studies have done previously (Bell et al., 2011; Chaudron et al., 2005; Cruwys & Dunaseelan, 2005; Interian et al., 2001). While there is an existing body of literature that has examined maternal depression among Latinas, research has centered largely on acculturation status and stress (Elder et al., 2005; Heilemann, Frutos, Lee, & Kury, 2004; Newcomb & Carmona, 2004) often overlooking the potential role of stigma. Additionally, existing research examining the relationship between acculturation and depression is mixed, at times contradictory, and inconsistent in the measurement of acculturation. Many studies measure acculturation by one variable, language, which excludes a number of other important cultural and contextual variables that may be significant. It is these
contextual factors that are imperative in understanding the experience of maternal depression in Latinas. Qualitative research affords the opportunity to include these rich narratives, not typically captured in the quantitative research.

Additionally, factors impacting the experience of depression and barriers to service seeking vary across settings and geographical regions; therefore, it is essential to understand these experiences at a community level. The Latino/Hispanic population is growing at a faster rate in Oregon compared to the U.S. as a whole, and reached 473,729 by 2014, 85.6% of whom were of Mexican descent. Since 2000, the number of Latino/Hispanics in Oregon has grown by 72% as compared to 50% across the nation, though this rate may be higher as some immigrants may be missed by U.S. Census data (Ruffenach, 2016). Nearly one-third (29%) of Latino/Hispanics in Oregon lack health insurance and 28% live in poverty, despite higher participation in the workforce than white Oregonians: 72% of Latinos versus 61% of white Oregonians (Ruffenach, 2016). Researchers estimate the Latino/Hispanic population will reach 119 million by the year 2060, 28.6% of the total U.S. population by that date, which intensifies the need to understand the experiences and contextual factors such as poverty, culture (e.g. language), mental health rates, and barriers to services impacting the Latina population in Oregon at a community level. Given these experiences and contextual factors can be hard to capture through quantitative research, qualitative methods offer the opportunity to understand how these variables interact to create barriers to identification and treatment of maternal depression.

**Statement of the Problem**

The current social (e.g. surging white nationalism) and political climate (e.g., border wall proposal, ICE raids, potential end of Deferred Action for Childhood Arrivals (DACA)) has
resulted in detrimental and sometimes catastrophic ramifications for Latino/Hispanic individuals including deportation and lack of services. The increasing threat facing Latino/Hispanic individuals and families creates additional stress and fear that disproportionately contributes to mental, emotional, and physical health issues. New sanctions, discriminatory policies, and threats to families are on top of existing adversity facing this community including higher rates of poverty, mental health issues, lack of culturally appropriate access to services and resources, and lack of insurance. In addition to the current political climate, Latinas face a number of adverse experiences that already contribute to an overall social health crisis. Specifically, Latinas face multiple social determinants of health affecting themselves and their families. As defined by the World Health Organization (WHO), social determinants are “conditions in which people are born, live, grow, work, and age” (2014). These health conditions are related to cultural, economic, social, and environmental factors (Oliveira et al., 2017). Thus, health is determined by the context in which people live. For Latinas, this equates to one quarter of the population living in poverty. Additionally, research suggests gender plays a role in the experience of depression among the Latina community (Cano, 2003; Hayden et al., 2013; Jezzini, 2013; Navaro, 2014; Nunez et al., 2015). Latinas internalize family values (familismo) often ignoring their own needs in order to care for, nurture, and maintain their family unit, while the role of self-sacrifice (marianismo) further puts the needs of the family ahead of a woman’s own needs and normalizes suffering (Hayden, Connelly, Baker-Ericzen, Hazen, & Horowitz, 2013). Marinaismo emphasizes the ideal of moral superiority like the Virgin Mary as a wife and mother by putting other’s individual needs (e.g., husband, children, and family) above their own and sacrificing their own needs (Navarro, 2014). A woman who adheres to this value of marinasismo receives respect, admiration, and honor from her family and community. Moreover, she may be
viewed as untrustworthy and selfish should she deviate from the ascribed role (Gil & Vasquez, 1996). This may create a vulnerability to stressors that potentially puts Latinas at increased risk for depression. Previous research suggests marianismo may be associated with health outcomes in Latina women, including higher symptoms of depression (Cano, 2003; Pina-Watson, Castillo, Ojeda, & Rodriguez, 2013).

It is imperative to understand the impact of maternal depression in the Latina/Hispanic community because not only do Latinas experience higher rates of depression, they have higher birth rates than other ethnic minority groups and are projected to make up 24% of the female population in the U.S. by the year 2050 (US Census Bureau). Latinas face a number of personal and cultural barriers that may impact their ability to (1) identify the presence of depression, and (2) to access and maintain treatment for depression. Given a wealth of research enumerating the negative outcomes for children with depressed mothers (Anderson & Hammen, 1993; Ashman, Dawson, & Panagiotides, 2008; Bagner, 2010; Conroy et al., 2012; DeRose, Shiyou, Levey, Helm, & Hastings, 2014; Tompson, Pierre, Boger, McKowen, Chan, & Freed, 2010), it is critical to understand the experience of depression in Latina mothers not only for their sake, but their families as well.

Research regarding maternal depression among Latinas has centered largely on acculturation status and stress (Elder et al., 2005; Heilemann, Frutos, Lee, & Kury, 2004; Newcomb & Carmona, 2004). Moreover, existing research is mixed and at times contradictory: some studies suggest maternal depression increases with acculturation (Heilemann, Frutos, Lee, & Kury, 2004), while others show a decrease in mental health problems (Newcomb & Carmona, 2004), or no significance (Elder et al., 2005). Researchers have conjectured this may be due to inconsistencies in the way acculturation is defined and measured (Andrews, 2013; Koneru,
2007), while others posit there may be other variables impacting the experience of depression (e.g. mental health stigma, lack of access to resources) that should be examined (Rastogi, Massey-Hastings, & Wieling, 2012; Schwartz, 2010). The process and effect of acculturation on well-being among Latinas has emerged as a growing field of research in recent years, but it is now more needed than ever given the current political and social climate in this country. Current policies have significantly limited or done away with programs to expand our borders.

Communities across the United States are changing and need research to examine, on a local level, the impact of these new policies on its citizens. Given the Latina/Hispanic community in Oregon differs from other Latina/Hispanic communities across the country, it is imperative to examine the experience of our community members and elicit the voices of key stakeholders who work with the local Latina community to inform future directions in research, and identification and treatment of mental health issues within the Latina community in Oregon.

The existing body of literature indicates Latina mothers experience higher rates of depression and lower rates of treatment than other ethnic and racial groups. It also indicates that mental health stigma and acculturation are significant variables in the experiences of depression for these women. However, given gaps in the literature and mixed results, there are many questions left unanswered in understanding what factors contribute to the experience of maternal depression and serve as barriers to the identification and treatment of depression in this community specifically. Including key stakeholders, who as professionals and members of the community and may be able to speak to the important factors not captured in quantitative studies, should be a focus of research to reduce barriers to identification and treatment, with the end goal of reducing the prevalence of depression itself.

Chapter 2
Running head: MATERNAL DEPRESSION IN LATINAS

Literature Review

Maternal Depression

Latinas experience higher rates of depression than African American and Caucasian counterparts (Shattell, 2008). Moreover, 30.2% of Latinas experience psychiatric disorders across the lifetime, including depression. According to the largest and most recent study of depression in the Latino/Hispanic community, the overall prevalence rate was 27%, with women twice as like as men to experience high depressive symptoms (Wassertheil-Smoller et al., 2014). Moreover, 63.7% of Latinos who experienced depression in the past year did not receive mental health treatment (Algeria, 2007).

The social, behavioral, physical, emotional, and mental impact of depression is well known and documented (Gilmour & Patten, 2007; Guo, 2012; Pratt & Brody, 2014). Further, maternal depression has repeatedly been linked with adverse child developmental outcomes (Anderson & Hammen, 1993; Ashman, Dawson, & Panagiotides, 2008; Bagner, 2010; Conroy et al., 2012; DeRose, Shiyko, Levey, Helm, & Hastings, 2014; Tompson, Pierre, Boger, McKowen, Chan, & Freed, 2010). Children who experience maternal depression face deleterious behavioral, social, cognitive, physical, and emotional outcomes. These children also show a decrease in cognitive function (Conners-Burrow et al., 2014; Petterson & Albers, 2001), poorer social skills (DeRose, Shiyko, Levey, Helm, & Hastings, 2014; Hammen, Shih, Altman, & Brennan, 2003), dysregulated emotion (Maughan, Cicchetti, Toth, & Rogosch, 2007), increased aggression (Barry, Dunlap, Lochman, & Wells, 2009; Gross, Conrad, Fogg, Willis, & Garvey, 1995; Malik et al., 2007; Pugh & Farrell, 2001), increased externalizing and internalizing behaviors problems (Bagner, Pettit, Lewinsohn, & Seeley, 2010; Campbell, Matestic, Stauffenberg, Hohan, & Kirchner, 2007; Coyne & Thompson, 2011), and increased mental
health issues including suicidality (Bureau, Easterbrooks & Lyons-Ruth, 2009; Garber & Flynn, 2001; Klimes-Dougan, Lee, Ronsaville, & Martinez, 2006; Klimes-Dougan et al., 1999). Children of depressed mothers experience poorer health (e.g., obesity, decreased brain activation, asthma) and are more likely to receive acute care and less likely to receive preventative care (Ashman, Dawson, & Panagiotides, 2008; Perry, 2007; Topham, 2010; Turney, 2011), which is expensive and associated with poorer outcomes. Given birth and immigration rates are highest among Latinas compared to other minority groups, and projections estimate Latina women will comprise 24% of the female population in the United States by 2050 (Beck, 2005), it is critical to acknowledge the potential impact maternal depression has on Latinx/Hispanic children.

Depression, including maternal depression, is a treatable mental health issue – and yet if undiagnosed and untreated, outcomes can exponentially affect mothers and their families. Further, preventative treatment reduces health care costs for mothers and children overall. Specifically, Perry (2007) found costs associated with managing pediatric asthma decreased significantly after mothers received anti-depressant treatment from 1-3 and 4-6 months after start of treatment. A better understanding of the barriers to identification and treatment of depression among Latinas has the potential to positively impact generations to come.

**Acculturation**

**Definitions and models of acculturation.** Although definitions vary greatly, acculturation can broadly be defined as the process by which individuals adapt to a new living environment and potentially adopt the norms, values, and practices of their new host society (Abraido-Lanza, Echeverria, & Florez, 2016). However, one of the inherent problems with research on acculturation is variable definitions and inconsistent measures across studies among the Latino/Hispanic community, which makes firm conclusions about its relationship to mental
health outcomes challenging. Early research on acculturation proposed a unidirectional model described as an inevitable process by which the immigrant ethnic group had to make major accommodations and develop the “memories, sentiments, and attitudes of other persons and groups and, by sharing their experience and history…[become} incorporated with them in a common cultural life” (Park & Burgess, 1969, p. 113). Others defined it as the process by which assimilation was achieved, or as defined by Warner and Srole (1945), “a process in which ethnic groups unlearned their inferior culturally based behaviors” (p. 151). Critiques of this unidimensional, and frankly racist approach highlight conceptual issues with the definition and measurement of acculturation as this unidimensional approach prohibits a person from being acculturated to both cultures simultaneously and emphasizes the importance of relinquishing aspects of an inferior culture.

More recently, bidimensional models of acculturation have emerged proposing adhering to a new dominant culture is independent of maintaining the original culture (Lara, 2005). The most prominent and current theory developed by Berry (1980) posits receiving culture acquisition and heritage culture retention are independent dimensions. According to this model, these two dimensions intersect to create four acculturation categories: marginalization (i.e., rejects both the receiving and heritage culture), separation (i.e., retains the heritage culture and rejects the receiving culture), integration (i.e., retains heritage culture and adopts the receiving culture), and assimilation (i.e., discards the heritage culture and adopts the receiving cultures; Shwartz, Unger, Zamboanga, & Szapocznik, 2010). Transition into one of these categories assumes an individual has control over these domains, however, this is not necessarily the case as separation or marginalization can result from environmental circumstances such as racism, policies or laws, prejudice, context of immigration, and societal norms (Lara et al., 2005). Thus,
significant variability may exist at the individual level in regard to the acculturative process due to contextual factors that are likely to serve as mediators. Broadly, however, Marin (1992) posits the acculturation process can be described on three levels. The first level is considered the most superficial level as it examines changes in aspects such as food and media. The second, or intermediate level, consists of behaviors that are a core part of a person’s social life such as language preference and use and identity of social network. The final, more significant level, has to do with maintenance or retention of an individual’s original culture and the adoption or rejection of new values or norms. Thus, the acculturative process is not a universal nor linear process, but a dynamic one that occurs based on the location in which the individual lives and develops. Each of these contextual factors need to be considered when examining the impact of acculturation on the experience of depression among Latina mothers. Recent research suggests Berry’s integration category is associated with the most favorable outcomes (Coatsworth, Maldonado-Molina, Pantin, & Szapocnik, 2005; David, Okazaki, & Sae, 2009). These individuals appear to be well-adjusted, experience lower rates of depression, and have higher self-esteem and more prosocial behaviors (Chen, Benet-Martínez, & Bond, 2008; Schwartz, Zamboanga, & Jarvis, 2007; Szapocznik, Kurtines, & Fernandez, 1980).

**Challenges facing researchers.** Recent research suggests acculturation is not a static, linear process of cultural adaptation to a new host society, but rather involves a dynamic exchange between new members of a society and host members (Abraido-Lanza, Echeverria, & Florez, 2016). Several studies suggest mental health problems decrease with increased acculturation (Crocket at al., 2007; Hiott et al., 2006; Heilemann et al., 2002; Wilkinson et al., 2006). Acculturation research is mixed, however, and the variability in the research may be due, in part, to the lack of consistency in how acculturation is defined and measured. For example,
language is only one indication of acculturation, however, it is commonly used as the sole aspect of acculturation in research. In one study, in households where English was the primary language, women who did not prefer to speak English experienced greater depression than women who spoke English (Schallmoser, 2003). The same finding emerged for women who experienced a language discrepancy between themselves and their social network (Martinez-Schallmoser, 2003). A recent study demonstrated the Somatic Anxiety Subscale and the Positive Affect Subscale operated differently between “nonacculturated” and “acculturated” women of Mexican descent and showed physical complaints were a significant indicator of depression among “nonacculturated” women. A significant limitation of this research, however, is the language used to identify certain symptoms or disorders may not translate sufficiently between cultures. Additionally, women of Mexican decent were more likely to endorse positive affect items compared to their counterparts, even when total anxiety scores were the same (Nguyen, 2007). These results suggest orientation toward mainstream U.S. culture serves as a significant vulnerability and may lead to increased levels of depression (Torres, 2010). More importantly, less acculturated women report symptoms of depression quite differently (Nguyen, 2007).

**Variable research findings.** One of the reasons researchers and clinicians struggle to meet the needs of women experiencing depression in the Latina/Hispanic community is inconsistent research findings between acculturation and maternal depression (Beck, 2006; Crocket et al., 2007; Heilemann et al., 2002; Hiott et al., 2006; Masten et al., 2004; McNaughton et al., 2004; Wilkinson et al., 2006;). Masten (2004) suggests the lack of significance may be due to the generational differences rather than acculturation status. Additionally, Masten’s study of Mexican immigrant women found no direct relationship between acculturation and depression when acculturation was measured as maintaining cultural values and adapting to U.S. society
In fact, no significance was found even when English language and time spent in the U.S. were the only acculturation variables used to test the relationship (Masten, 2004). While most of the existing research does support the relationship between acculturation and depression, there is some evidence it is a more complex issue. In fact, a small number of studies have found that other factors such as social capitol, family social support, intercultural competence, mastery, and resilience play an important role (Heilemann, 2002; Rivera, 2007; Valencia-Garcia, 2012). Given the shift in the values, norms, and practices as one adapts to a new environment, it is important to examine how this shift may impact Latina/Hispanic mental health. One explanation is it becomes more acceptable for a Latino/Hispanic parent to recognize and discuss mental health issues such as depression, thus, making the identification and report of mental health status the piece that changes, not the existence of depression itself (Koneru, 2007). However, it may also be there are barriers Latinas face that are not measured by acculturation alone, such as lack of identification of depression and barriers to seeking services (Clement, 2015; Lagomasin et al., 2005). In this scenario, there may be a large number of newly immigrated Latino/Hispanic individuals and families impacted by maternal depression who are falling through the cracks, necessitating further research to understand the complex interplay of acculturation and mental health.

**Mental Health Stigma**

Mental health stigma is broadly defined as a multidimensional process of objectifying and dehumanizing a person because of being labeled as “having a mental disorder” (Masuda, 2004). It is this fear of being stigmatized, disgraced, or socially sanctioned that governs many aspects of human behavior. In many instances, the fear of stigma does not result in actual behavior change, but rather leads individuals to hide certain actions or behaviors (Bharadwaj,
2017). Mental Health stigma has been linked to an increase in psychological distress and decrease in psychological flexibility (Masuda et al., 2009), decreased self-esteem (Corrigan & Watson, 2002), unemployment (Link, 1987), poor social adjustment (Perlick et al., 2001), a reduction in help seeking and use of services (Clement, 2015; Corrigan, 2004; Kushner & Sher, 1991), treatment delay (Starr, Campbell, & Herrick, 2002), and negative emotions and cognitions (e.g. pessimistic view regarding cause, prognosis, and treatment of a mental disorder; Masuda, 2004). Bharadwaj (2017) found that of those observed through tracking of prescription medication used to treat depression, 36.5% did not report they had been diagnosed with either depression or anxiety. The under reporting for all other diagnoses (including physical health such as diabetes) was lower at 17%. For those who had been treated for depression for short periods of time, the rate of under reporting mental illness was 50%. While these results of under reporting are cause for concern, what is even more alarming is many people never pursue treatment at all, and others begin treatment, but fail to fully adhere to services (Corrigan, 2004). Clement et al. (2015) found stigma was reported as a barrier to care seeking due to shame/embarrassment, negative social judgment, discrimination, and disclosure/confidentiality – the latter ranking the highest with 32% reporting this as a barrier. However, in this meta-analysis, examination regarding the impact among the Latino/Hispanic population often was invalid or non-significant due to small participant samples, which compounds the difficulty of understanding the impact of mental health stigma among Latina mothers experiencing depression.

Broadly, Latinos/Hispanics are less likely to initiate mental health care (Cook et al., 2014), half as likely to start antidepressants (Harman, Edlund, & Fortney, 2004), and more likely to discontinue medications within the first 30 days of treatment (Olfson, Marcus, Tedeschi, &
Wan, 2006). Research suggests Latinos may not reliably identify the “Western” or diagnostic characteristics of depression from a vignette (Vega, 1991). Additionally, weakness and inability to handle life’s problems, failure, and thinking one is crazy were all identified as significant stigma associated with depression (Interian, 2007). Immigration status (or fear of it being known), mistrust of health care professionals, myths about addictive attributes of anti-depressants, and the cultural value that problems should not be discussed outside the family have all been shown to contribute to the stigma regarding subjective reporting of depression among Latino/Hispanic populations (Cooper et al, 2003; Cruwys, 2015). Given the impact stigma has, not only on subjective identification of depression, but on reporting as well, research and clinical practice must consider stigma when examining mental health status among Latinos/Hispanics. The cultural resistance to identifying and reporting depression may impact the identification and treatment of depression broadly, and maternal depression specifically, within this population. However, little research exists examining mental health stigma among Latinas specifically.

**Qualitative Research on Depression, Acculturation, and Health Stigma Among Latinas**

Qualitative research examining potential barriers to identification and treatment of maternal depression among Latinas is scarce. Most of the limited research looks at the Latino/Hispanic population in general, and not specifically mothers (Caplan et al., 2013; Saver 2007; Vega, 1991) One study conducted qualitative interviews with 20 low income Mexican-born mothers and found mothers identified challenges associated with motherhood including doubting their ability as a mother and limited ability to manage their own emotional vulnerability contributed to their difficulty maintaining emotional health (Ornelas, 2009). These mothers also identified family separation, social isolation, discrimination, not speaking English, economic pressures, and feeling less freedom in the U.S. due to fears as contributing to mental health...
issues. In contrast, they identified support from family and their community as a protective factor for experiencing depression.

While only a handful of studies have been conducted with the Latino/Hispanic population in general, the limited number provide rich information about how individuals in the community view depression and barriers to treatment. Common causes of depression were linked to life circumstance such as trauma, abuse – both physical and sexual, alcohol abuse, and loss of a loved one (Caplan, 2013; Pincay, 2007). Other cultural factors were identified such as ambition, punishment from God, payback for sins, finding the U.S. stressful, racism, and discrimination (Caplan, 2013; Lazear, 2008). Financial pressure and factors associated with economic issues (e.g., housing, transportation, medical insurance, employment, access to resources), immigration status, and psychosocial stressors (e.g., isolation, family separation due to immigration, discrimination, and language barriers) emerged as significant themes across multiple studies (Lazear, 2008; Ornelas, 2009; Pincay, 2007).

Four studies looked specifically at barriers to seeking treatment and each identified mental health stigma, fear of being viewed as crazy, language (not speaking English), and lack of health insurance as significant barriers (Lazear, 2008; Pincay, 2007; Rastogi, 2012; Uebelacker, et al., 2012). Additional barriers included trust in family, friends, and providers (Lazear, 2008; Uebelacker, 2012), worry about security of privacy of their information (Uebelacker, 2012), financial concerns, immigration status (e.g. fear of being discovered), transportation, lack of knowledge of where to go, perceived coldness of providers, lack of understanding of mental health treatment (Pincay, 2007), and lack of understanding about depression (Saver, 2007).

Pincay (2007) also identified themes regarding attitudes toward treatment and providers. Specifically, participants frequently identified believing you should deal with your problems on
your own, and medications are only for those who are severely mentally ill. Participants also reported depression is the result of life circumstance and not an illness requiring treatment. Themes regarding attitudes toward providers identified participants seek help from primary care providers because they were not aware of available mental health services. Language barriers and cultural clashes between individuals and providers were identified as challenges. Finally, participants stated providers need to be more accessible, they lack initiative in building trust with their clients, and fail to treat their clients with respect. One participant stated:

“What happened is that I arrived [at therapy] and he listened to me and he was looking at his watch. And I was telling him everything I felt, everything that had happened. And he said, ‘I’ll wait for you at our next appointment.’ That was all he said. I don’t go anymore. I don’t have time to waste like that.” (Pincay, 2007, p. 23)

While the existing body of qualitative research is small, it provides important information regarding the contextual factors impacting the identification and treatment of depression among Latinas. Future research should include key community stakeholders, which currently does not exist in the literature, which may lend further insight into barriers facing these individuals.

**The Current Study**

Strong theoretical arguments support the use of qualitative methods to promote exploration and increase sensitivity to phenomena under investigation (Charmaz & Henwood, 2010; Corbin & Strauss, 1990). Specifically, while scientists bring a personal perspective to research, a research question should take the form of identifying the phenomenon to be studied and understanding what is known about the subject (Glaser & Stauss, 1967). Grounded theory systematically leads to identification of conceptual categories and themes (Health & Cowley, 2004). By specifically focusing on problems and issues related to people’s activities,
interactions, sense-making, and location within particular settings, grounded theory generates core variables and main concerns. Further, grounded theory commonly employs interview data to develop coding schemes (Bryant & Charmaz, 2012; Henwood & Pidgeon, 2003). The aim of grounded theory is to explore social processes and to understand the multitude of interactions that produce variations in the process (Heath & Cowley, 2004). Grounded theory has a long-standing association with symbolic interactionism, which seeks to explore the activities and interactions involved in the symbolic and interpretive production of social and cultural worlds (Henwood & Pidgeon, 2003). Additionally, constructivism (important to the process of symbolic interactionism) involves the researcher in a creative and interpretive process of gathering data and generating new understanding (Bryant & Charmaz, 2012). Thus, the process of grounded theory involves simultaneous data gathering and coding, which can help to reform and refine questions asked to study participants during interview. Broadly, the researcher typically works from an initial research question, gathers data through interviews, analyzes or codes the data, gathers more data and conducts additionally analyses, until a satisfactory saturation is reached. A Grounded Theory informed design was used in the current study.

The primary aim in the current study was to identify key factors contributing to the experience of maternal depression among Latinas in western Oregon. This Aim included identifying aspects of culture, barriers to identification and treatment, mental health stigma, access to services, and examining whether there are barriers stakeholders face and believe community members also face that are not captured through larger qualitative studies. It was hypothesized specific themes would emerge during analysis that would inform the interpretation of the experience of maternal depression among Latinas in western Oregon – not just the prevalence, but also the identification of it. Two primary hypotheses were tested in the current
study: 1) Acculturation was hypothesized to be a significant variable as there may be groups that emerge based on acculturative status of participants in the second study; 2) Mental health stigma and its contribution to psychological distress, as well as shame, was hypothesized as an important barrier keeping mothers from identifying depression and seeking treatment. This is an important aspect of the experience of depression that is difficult to capture through quantitative measures.

One on one interviews with key stakeholders were conducted to facilitate the communication of issues pertaining to maternal depression among the Latina/Hispanic population in western Oregon and strengthen the capacity to understand the situation. Additionally, while the researcher generated initial hypotheses, she remained sensitive to the interpretations and meaning given by those whose social world was being studied (Becker, 1993). One on one interviews with key community stakeholders allowed identification of relevant factors impacting Latinas and how the needs may differ from other communities in this country.

Given the current body of literature suggests that acculturation plays a significant role in maternal depression, the current study aimed to understand stakeholders’ perception of the role acculturation plays on the experience of depression. Additionally, given that mental health stigma contributes to psychological distress and shame, stakeholders were asked whether they believe this is a barrier that keeps mothers from identifying depression and seeking treatment. Additionally, given that key stakeholders have a unique opportunity to speak about the experience of maternal depression from the side of service providers within the community, it was important to get an understanding of potential barriers service providers may face in identifying and treating maternal depression in the Latina community. Thus, an open-ended
question was included regarding this topic (See Appendix A), which may provide rich information not typically captured through larger qualitative studies.

Chapter 3
Methodology

Procedures

A set of 5 open-ended interview questions was developed and used (see Appendix A) based on the overall research question and existing literature. Interview questions addressed various aspects of Latina/Hispanic women’s experiences to elicit information on possible barriers to health care, stigma regarding mental health, cultural factors (e.g., language, values, assimilation, marginalization, social supports), awareness of depression within the Latina community, access to services, and utilization of services. Additionally, participants were asked to identify barriers to identification and treatment of maternal depression faced by service providers. While the initial interview structure was predetermined according to the primary research questions identified previously, follow up questions and discussion were open ended and based on answers provided by participants.

Key stakeholders were defined as persons over the age of 18 who spoke English or Spanish and worked with the Latina/Hispanic community as their primary focus (e.g. community center, health care setting). A sample of providers was recruited as each of these positions possessed unique viewpoints and experiences that contribute to the data as their roles and interactions within the Latina community were quite different. Participants consisted of individuals from a diverse set of organizations including county and state services, private health care organizations, medical clinics, non-profit organizations, school districts, counseling centers, and a local university. Charmaz (2006) suggests it is the aims of the study that are the ultimate
driver of adequate sample size, while others state it is the scope of the study and quality of data (Ritchie et al, 2003). However, Bertaux (1981) states a sample size of 15 is the smallest acceptable sample in any qualitative research and Creswell (1998) states 20 is adequate for saturation. Thus the current study aimed to obtain 15-20 participants. According to Grounded Theory, saturation is reached when new themes no longer emerge from the data (Smith, 2015), which occurred after interview 13. However, to ensure saturation, three more interviews were conducted at which point saturation was confirmed.

Participants

**Recruitment.** Key stakeholders were recruited through existing contacts (e.g. Familias en Acción, Kaiser Permanente, and Centro Cultural), as well as with flyers, phone calls, and emails to individuals who work with the Latina/Hispanic community in some way. Additionally, contact was made through Faculty at Pacific University who were able to provide introductions to key stakeholder. Finally, the Primary Investigator (PI) reached out to organizations in the greater Portland area who may be able to provide references to individuals and organizations eligible to participate.

Interviews were conducted at various locations for convenience of participants. Informed consent was conducted in person prior to the start of each interview and participants were provided a $15 gift card for participation in the study. For participants who preferred Spanish or did not speak English (or preferred to conduct the interview in Spanish), a professional interpreter was used. Open, line-by-line coding of data was started after two initial interviews had been conducted. This data was compared for similarities and differences, and more data was collected. This back and forth between gathering of data and analysis continued throughout the study. Memos are a common practice in grounded theory and are a place to record and explore
ideas during the analytic process. Grounded theory uses memos to compare data, define gaps in data collection, develop analytic categories, and are helpful for analytic precision and establishing theoretical relationships (Smith, 2008). Interviews were recorded and transcribed for coding and analysis.

**Demographics.** Providers held positions such as community health workers, clinical psychologists, social workers, nurse case managers, promotores, Women, Infants, and Children (WIC) case managers, doulas, state employed regional family educators, county nutrition technicians, patient navigators, maternal child health county employees, and a community liaison for a local school district. All of the participants held positions in which they specialized in working with Latina mothers. A few of the participants identified as bilingual, however, they expressed preference for answering questions in Spanish so an interpreter was provided. Participant racial/ethnic identity was posed as an open-ended question so participants could express how they identified rather than choosing from a pre-determined list. Detailed demographic information is provided in the results section.

**Data Analyses**

In order to capture the contextual experience of maternal depression among Latina mothers in the community, interviews with key stakeholders were recorded, transcribed, and imported to NVivo to code the data for themes that were present across interviews. Two coders were used to ensure validity and reliability. Per Grounded Theory methodology, analysis was conducted concurrently with data collection and themes were developed as they emerged from the data. This helped the investigator to stay true to the tenet of Grounded Theory, which allows the researcher to discover knowledge based on the data presented rather than preconceived notions about what might emerge. As an example, the question regarding the experience of
depression originally sought to understand key stakeholders’ views of the prevalence of depression among Latina mothers. However, it quickly became apparent that prevalence was not an aspect of depression that participants presented viewpoints on. Additionally, they had much more significant and rich information to share regarding what they viewed as relevant regarding the experience of depression, thus the question was adjusted to mirror the emerging data. In addition, memos were used throughout the process to record personal thoughts and feelings apart from the analysis of theoretical concepts. This is a core principle of Grounded Theory methodology (Oktay, 2014), which includes writing definitions of categories, justifying labels, tracking emerging relationships, and keeping record of the progressive integration of higher and lower level categories. Memos showed changes in direction in the analytic process, emerging perspectives, and the adequacy of the research question. Initially, line by line coding was used to identify themes present in the data. This was followed by a focused, and selective phase in which the data was sorted and synthesized. Themes were coded using the hierarchical parent-child node system in which overarching themes are the parent node and child nodes represent themes within that parent node. NVivo reports both percentage agreement and Kappa Coefficient. A Kappa Coefficient of .80 is sufficient for inter rater reliability and was used to assess reliability (Willig & Stainton-Rogers, 2010). Inter rater reliability was calculated and resulted in a Kappa Coefficient of .92.

Chapter 4

Results

Community Stakeholders

Sixteen participants were interviewed across a variety of organizations including private medical facilities, school districts, county services, mental health clinics, non-profit
organizations, state services, and private universities. The mean number of years for working with Latina mothers was 13.78 years, providing a wealth of experience and rich history for which they were able to speak. Of the 16 participants, two spoke English, two spoke Spanish, and the rest identified as bilingual or spoke more than two languages. Four of the participants identified as Caucasian, while 12 identified as Latina, Mexican, Hispanic, Venezuelan, Columbian, or Indigenous (see Table 1 for complete demographic information).

While many of the themes across questions overlap or were related, they were kept separate to provide clarity in how participants conceptualized each of the explored categories. For instance, several of the variables identified aspects of acculturation as a factor contributing to the experience of maternal depression, however, some of the richness that comes with qualitative data would be lost by collapsing them and thus they were kept separate. Additionally, there was enough saturation for them to exist as themes in and of themselves.

Social Location of Participants and Investigator

One of the guiding principles of Grounded Theory is the constructivist view of the researcher as part of the process of critical inquiry (Charmaz, 2014). It takes into account the social location of both the person conducting the researcher and the participants. Thus, this consideration was a key aspect of the collection and analysis of data throughout the study. For instance, in conducting interviews, the investigator was cognizant of the fact that she is not a member of the Latina community and does not speak Spanish – both of which could potentially impact the information provided by participants. Given this, it was important to find ways to establish a sense of trust and safety during the interviews to allow participants to speak freely. The potential privilege associated with the role of researcher was considered as well as the investigators role as a student, rather than a professional. This appeared, at times, to put
participants at ease as did the investigators gender (female) and ethnic identity as a person of color. Most participants had at least one factor in common with the investigator. It was also these variables that were considered throughout the analytic process in order to be aware of any potential bias in the coding process.

Through this reflective process of critical inquiry, it became apparent that many of the participants answered questions with the assumption that they were being asked about Latina mothers who had immigrated to the US, rather being born in the US. This appeared to happen more often in the older participants who were also immigrants rather than the Caucasian or U.S. born individuals. Thus, while the population was not specified by the investigator, the results of this study speak mainly to Latina mothers who have immigrated to this country rather than mothers who were born in the U.S.

**Experience of Maternal Depression**

Sixteen themes emerged with regard to the experience of maternal depression among Latina mothers (Table 2). While most participants did not feel they could speak to the prevalence, they all spoke to the factors they believe contribute to the presence of depression. Ninety-four percent of participants spoke to isolation or lack of support as being the main contributor to the experience of depression for Latina mothers. Specifically, participants spoke about the importance of family and community for these women in their home countries, and how that social network was often no longer present for them in this culture. Related to this, but separate, 81% of participants believed issues around sense of identity when faced with the acculturation process impacted the existence of depression. One participant stated:

“…your ethnic identity is related to your psychological distress and your resiliency factors. And so if you're not as connected to those parts of your identity, then your risk
factor for any kind of psychological distress, in this case depression, is going to be higher.”

This confusion about identity, or more specifically of feeling like one is caught between two cultures, and attempting to figure out their way, or not engaging in the acculturation process was a significant contributor to the experience of depression according to participants. Another aspect of identity that participants felt contributes to depression among Latina mother’s is the expectation they hold as mothers and providers for their family. They often spoke about mothers’ distress in feeling as though they were not fulfilling this role in some way (e.g. having to work rather than being at home with their children). They also spoke about the guilt and shame that mothers felt for experiencing depression when they felt they should be happy because they have children and a family. Another key aspect of the experience of depression that providers observed is that women tend to present with more somatic or behavioral symptoms:

“I've seen a lot of Latina women presents with headaches and backaches and sadness and withdrawal. That in the absence of other medical diagnoses is really more of a depression. I think a lot of times it manifests itself relationally in strained relations with children or what their partners a lot of stress, feeling overwhelmed.”

The reason for this presentation may be explained by the barriers to identification and treatment discussed later. Seventy five percent of participants reported immigration status as a contributor to depression due to the added stress it provided in things such as employment and concern about being deported, among other worries. Other themes that emerged were the political climate, domestic violence, language (not speaking English), lack of resources, discrimination, fear, employment issues, Socioeconomic status, interpersonal strain, and trauma during immigration.

In discussing the experience of depression, 63% of participants spoke to the benefits of
participating in groups for these women, but not mental health groups. Other types of groups such as parent support groups, nutrition education classes, fitness classes, and other information groups were reported to be more impactful. Key stakeholders discussed how participation in these groups helped women create meaningful relationships and a sense of community. Moreover, it was through these groups that women began to share their experiences and eventually talk about their symptoms of depression, which in turn decreased their symptoms. Participants reported this more culturally adaptive setting (e.g., talking, sharing food) may be a more effective way of addressing depression among these women than traditional, western approaches. These results speak to participants beliefs that it is not just language that serves as a barrier for service providers, but their inability to adapt treatment in a culturally beneficial way.

**Barriers to Identification and Treatment**

The barriers to identification and treatment proved to be the question that participants talked about the most as it provided the greatest number of themes. This may be due to not only their role as service providers, but also due to the fact that most of the participants were female members of the Latina community. Many participants not only spoke to the experiences of the mothers they work with, but had a plethora of examples and history to draw from in their own experiences as a mother and member of the community. Twenty-two themes emerged (Table 3) with all participants stating that knowledge of what depression is, as well as insurance/cost serve as the biggest barriers to providing services. There was an overall consensus that depression is not a term that is used or known in the Latina community.

“…when we talk about the depression not everybody are familiar with that word. We are, we hear about these words, like, because we work with them, but when we talk about depression or you have depression, they say what is that? They don't understand.”
Ninety-four percent of participants believed stigma surrounding mental health is a significant barrier to both identification and treatment as they believe women do not want to be associated with terms such as depression, and that if they seek counseling, others will think they are “loca,” or crazy. This is important given that it appears even if people were educated about what depression is, they would likely not seek treatment due to concerns about stigma associated with depression.

Eighty-one percent of participants viewed trust and safety, language, and lack of relationships with providers as barriers to treatment. They expressed an overall sense of mistrust for Americans, organizations, and service providers, as well as women’s concerns about being judged and thus not feeling safe to discuss aspects of their personal life. For those who do wish to seek treatment, participants stated many women do not speak English, which makes it difficult to reach out for help. Associated with this, participants expressed frustration that there are not enough service providers who speak Spanish and are able to treat Latinas. However, participants stressed it was not just about being able to speak the language, but having an understanding for the culture and how it differs from culture in the U.S. Participants also stated, for those women who do access providers, the women do not feel that they are able to create a relationship with a provider. These women walk away feeling as though they are just a number and that they do not matter as a result they do not return if they do not have to. This may speak to the one of the fundamental differences between collectivistic and individualistic cultures – the importance of cultivating relationships. Other aspects of culture that were viewed as barriers were not wanting to embarrass their family or themselves, tending to focus on family and children (e.g., not taking the time for themselves), role expectations (e.g., moms should be happy), religion, issues related to acculturation status (e.g., years in the U.S., connection to support network) and the
involvement of family in the process. Participants also presented things such as access to care, immigration status, navigating the health care system, lack of knowledge about resources, logistics (e.g. child care, transportation), education, and the political climate as barriers to treatment.

**Stigma**

Five themes emerged regarding the ways that stigma serves as a barrier not only to identification of maternal depression, but also to treatment (Table 4). Initially, participants discussed stigma around mental health in general, and how mental illness is viewed as severe and chronic psychopathology such as psychosis, or behaviors such as murder. One participant talked about this being how mental health issues are portrayed in telenovelas, or Spanish soap operas. A majority of participants (94%) talked about this stigma resulting in women responding to suggestions for counseling or mental health services for depression by asserting that they were not crazy or “loca,” thus they did not need it. Specific to depression, there was a belief that people who experience depression are lazy or are simply not doing enough – as though depression was a character trait rather than a mental illness. Along those lines, participants suggested the presence of stigma for mothers who experience depression, not only because of the previously mentioned stigma, but again because it must be due to some character flaw. A mother, who has beautiful children and a family, should be happy, and if they are not, there is some fundamental flaw in them. This contributed to women being hesitant to turn to others when talking about their experience. One participant stated:

“I think they, you know, some people might view it as you know, I'm a mother who's dealing with depression. People might think it’s because she's just too emotional, you know, maybe she's not able to adjust to the life of being a mother.”
The final aspect of stigma that was commonly mentioned (44% of participants), was concern about medications. More specifically, there exists a fear that medications for depression are addictive and that they will be viewed as addicts. Additionally, natural remedies such herbal treatments are considered a cultural norm and are more in line with their values and traditions.

**Impact of Acculturation**

While all participants viewed acculturation as having an impact on the experience of maternal depression, not all participants were familiar with this term, thus many tended to talk about cultural differences that contributed to depression rather than the process of acculturation itself. However, nine participants believed acculturation status to be a factor as they spoke to a sort of identity crisis that Latinas experience as they navigate a foreign culture. The viewpoints presented by participants is consistent with existing literature suggesting women in the integration phase of acculturation experience the greatest outcomes, while women in the marginalization or separation phase experience the most adverse outcomes. Fifty six percent of participants discussed the impact of coming from a collectivist culture and associated values associated along with attempting to thrive in a more individualistic culture. This, according to participants and consistent with the results regarding contributing factors to depression, appears to be an aspect of acculturation that has a significant and detrimental impact on Latina mothers. Along these lines, participants talked about the difficulty in navigating their traditions and values as a mother, wife, and family member as an aspect of the acculturation that impacts these mothers. They also discussed how they see mothers attempting to incorporate these values in their role, particularly when they do not coincide with service providers they come in contact with. Participants talked about things such as ways for caring for children, the family make up (e.g. grandparents in the home helping out), breast feeding practices, respect towards elders, and
traditions such as staying home with the baby for 40 days as being an important bonding period. When asked about the impact of acculturation, the last aspect that participants spoke to is the impact of language. Forty four percent of participants felt the acquisition of English creates empowerment, while the lack of English serves as a barrier for things such as becoming involved in their child’s school or impacting what aspects of the community they can navigate. They believed this lack of involvement contributing to the experience of depression.

**Barriers for Service Providers**

Many of the barriers identified for service providers were congruent with the barriers that participants believe Latina mothers face in seeking treatment. Eighty eight percent of participants believe that service providers generally due a poor job of building rapport or creating relationships with the people they serve.

“It’s not, I'm a provider, I'm gonna write everything that you gonna say. I'm gonna help you out because I'm the provider. It's not like that. It's more - if you don't have a good relationship you don’t have good communication with a provider.”

In addition to this, over half of participants (56%) felt the way processes are set up in organizations also serve as a barrier for treatment, partly due to the fact that they do not address this cultural value of building the relationship. The process they spoke of included the medical model, the way appointments are set up, clients being rush through short appointments due to a system that is set up to work quickly and efficiently, lack of flexibility on time, and long waits to see providers. Just as providers spoke about with barriers for Latina mothers, they expressed concern that there are not enough providers who speak Spanish or have an understanding of the culture. This contributed to a belief that service providers do not adapt treatment in a culturally
competent way, which alienates women from accessing services as well as continuing with services.

“So I guess, I mean and then not being Latina, it doesn't do it necessarily, but it just, it's a framework it’s what informs your work and who the person is, their relational aspect and their understanding of the history, some things, you know. You cannot be a veteran therapist if you don't understand anything about wars.”

A smaller portion of participants expressed the belief that lack of funding, only serving those with insurance, and compassion fatigue all serve as barriers for them as organizations and providers. This paints a picture of organizations and providers that are overworked and barely getting by with what they do have and can offer.

**Chapter 5**

**Discussion**

The purpose of this research was to identify key factors contributing to the experience of maternal depression among Latinas in western Oregon including aspects of culture, barriers to identification and treatment, mental health stigma, and access to services. The use of qualitative interviews allowed for a richness in the data that would not have otherwise been captured through quantitative methods. The information provided by participants both supported current research and provided new information that helps to understand not only what key stakeholders believe contributes to depression, but serves as a barrier to identification and treatment. In looking at this data as a whole, several things emerged as significant.

First, it appears, many of the aspects that contribute to the experience of depression, as well as serve as barriers to identification and treatment, have to do with aspects of acculturation. This confirms the original hypothesis that acculturation plays a significant role in the experience
of depression. The top six themes identified in the experience of depression as well as the top five out of six themes for barriers to identification and treatment, are all related to the contextual experience of moving to a country whose culture is fundamentally different. This supports previous research that indicates it is important to examine the contextual factors of acculturation as they appear to be significant variables in the relationship between acculturation and depression (Heilemann, 2002; Rivera, 2007; Valencia-Garcia, 2012), particularly in regard to social capital and isolation. While we know that social supports serve as a protective factor for depression for all individuals, however, it may be particularly important for these women given the collectivistic nature of the countries of origin.

Additionally, the lack of knowledge about depression, the presentation of symptoms, and stigma found in this study further supports findings in previous research (Clement, 2015; Cooper et al., 2003, Cruwys, 2015; Vega, 1991) and highlights the fact that providers may be attempting to use a label that is simply not familiar or acceptable to these women. It is akin to trying to put a square peg in a round whole. All 16 participants talked about the importance of education around depression, not only so that it becomes more familiar, but to normalize it and remove some of the stigma. Many participants discussed their attempts to normalize it by comparing it to health issues such as diabetes and stressing the importance of women learning it is not a fundamental flaw with who they are, but a health condition. Based on the results of this study, along with research previously mentioned, stigma continues to be a significant barrier in the treatment of depression for Latina mothers, as was hypothesized.

Second, the way participants discussed the cultural variables related to acculturation in this study are similar to concept of how they viewed the presentation of symptoms of depression. Many could speak to the specific variables associated with current models of acculturation, they
simply were not familiar with the concept of acculturation. Knowledge of the term acculturation was positively correlated with having a graduate degree in social work or psychology \( (r = .683, p = .003) \) suggesting that is through these participants’ education that they learn about this process. It appears, although aspects of acculturation may have a greater impact that some realize, they simply do not have the knowledge to speak to this process. The implications of this remain unclear and need further investigation.

Third, there were two unexpected findings that emerged in this study. First, even though participants were not asked about the current political climate, many of them believed it serves not only as a contributor to depression (56%), but also as a barrier to treatment (44%). Many of the participants spoke to the fear and concern for the safety of women in the community simply going outside of their home, citing the current climate in the U.S. as causing them to try and stay hidden, thus decreasing their engagement in their communities and serving as a barrier to seeking treatment with organizations they do not trust. Second, an aspect not previously seen in the literature, and unique to the experience of key stakeholders, is the emergence of compassion fatigue as a barrier faced by service providers working with Latina mothers. Several participants spoke of large caseloads due to several factors: lack of service providers in the community and in their organization, lack of funding, and organizations that are overworking their staff due to this lack of funding and providers. They shared their desire for serving their clients, but feeling exhausted and impeded due to constraints in the system, which led to concerns about the quality of care being provided. This is an important aspect of the treatment process that warrants more examination.

One of the limitations of this study is that it consisted of a small, fairly educated sample. While participants do represent a diverse population (e.g. various socioeconomic statuses, areas
of Portland, ages) it may be that some information was lost. Additionally, the timing of the study could potentially serve as a limitation, as despite participants not being asked about the current political climate, many of them spoke it as both a contributor to depression and a barrier to treatment. The methodological limitation of the study was that the primary investigator served as one of the coders during data analysis. While part of the Grounded Theory process does involve an intimacy with the data as one shifts between data collection and analysis, it should be noted that the investment of the investigator may have served as bias. However, this was combatted by the use of a second coder and calculating the Kappa Coefficient, which indicated reliability between coders. The final limitation of the study is the fact that the investigator does not speak Spanish. While an interpreter was used for those who did not speak English or preferred to conduct the interview in Spanish, the investigator’s lack of Spanish language may have impacted recruitment, as well as rapport with participants.

The major strength of the study was the use of broad and open-ended questions that allowed participants to speak to what they see as relevant in this community. Additionally, participants had a long-standing history working with Latina mothers as the mean length of time was over 13 years. This allowed for a familiarity not just with Latina mothers, but with service organizations for which they were able to speak about. Another strength was the diverse set of positions participants held and the various ways in which they worked with Latina mothers. While it covered a broad group of settings, it was clear key stakeholders believe Latina mothers face the same experiences and barriers across settings within the community.

There are several directions future research could take based on the results of this study. First, given that all participants talked about the need for education about depression, and mental health in general, it will be important to get an understanding of how effective current outreach
and education programs are. Additionally, of the individuals and/or programs that are successful, what is it about these programs that make them successful and what needs improvement? Many participants talked about the benefits of groups, which suggests research is needed to find the most effective ways to use culturally adaptive and appropriate groups as a form of treatment for Latina mothers. It seems depression symptoms may be ameliorated through the process of social interactions in a group, rather than a group specified for depression that includes social interaction. This appears to be more in line with culturally-based values and norms and addresses one of the top contributors to depression that participants spoke of. A literature review of group treatments by Stacciarini, O’Keeffe, and Mathews (2009) reviewed studies that had implemented some form of group treatment (i.e. psychosocial and behavioral, psychoeducation, cognitive behavioral group therapy) and found cognitive behavioral group therapy to be effective. However, few experimental studies explored culturally relevant variations in treatment, despite mentioning culturally relevant therapeutic factors. Second, it would be good for each organization to examine their own policies, processes, and practices as many participants spoke to issues faced by service providers. Additionally, many of the participants spoke about specific organizations they had been referred to as “Latina/Hispanic friendly” organizations who were deemed anything but friendly. It will be important for organizations to connect with the people they serve in order to evaluate their own programs and address and barriers they may be created for Latina mothers.

Conclusion

The goal of this study was to identify contextual factors that contribute to the experience of maternal depression for Latinas in western Oregon including aspects of culture, barriers to identification and treatment, mental health stigma, and access to services, and to examine
whether there are barriers stakeholders face and believe community members face that are not captured through larger qualitative studies. A Grounded Theory informed qualitative design was used to conduct one on one interviews with key stakeholders in the community to capture these factors. This data illustrates a system that attempts to treat a mental health issue that Latina women initially are not aware of. Current literature indicates Latinas face higher rates of depression than other demographics, yet the results of this study suggest they do not know how to identify it. This may mean there is an even larger number of Latina mothers experiencing depression than the literature indicates. However, the data also suggests that if there is knowledge of it, stigma prevents women from talking about it. This is problematic given the adverse outcomes, not only to these women, but to their children. For those women who do pursue treatment, there is a lack of accessibility for a variety of reasons: lack of knowledge of resources, cost, difficulty navigating the system, and language. Several participants shared the outreach experiences they have engaged in and talked about the need for more education. However, rather than asking Latina women to access the system, participants stressed the importance of providers reaching out to the community. In creating relationships before women seek treatment service, providers may be able to break down some of the barriers that the Latina community faces surrounding the experience of depression. Additionally, service providers need to adjust current treatment modalities, processes, and policies to better serve Latina mothers.
Running head: MATERNAL DEPRESSION IN LATINAS

References


Appendix A

Interview Questions

1. What is your experience with maternal depression among Latinas in this community?

2. How does acculturation impact the experience of maternal depression in the Latina community?

3. What are the barriers to utilization of services for maternal depression in the Latina community?

4. What are the barriers to health care providers serving the Latina community?

5. How does mental health stigma impact the experience of maternal depression in the Latina community?

Table 1.
### Demographic Characteristics of Survey Participants (n=16)

<table>
<thead>
<tr>
<th>Demographic Variable</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Language</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spanish</td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td>English</td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td>Bilingual</td>
<td>10</td>
<td>62.5%</td>
</tr>
<tr>
<td>More than two languages</td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td><strong>Gender</strong></td>
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</tr>
<tr>
<td>Male</td>
<td>1</td>
<td>46.7%</td>
</tr>
<tr>
<td>Female</td>
<td>15</td>
<td>53.3%</td>
</tr>
<tr>
<td><strong>Race/Ethnicity</strong></td>
<td></td>
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</tr>
<tr>
<td>Latina</td>
<td>5</td>
<td>31.25%</td>
</tr>
<tr>
<td>Mexican</td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td>Caucasian</td>
<td>4</td>
<td>25%</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2</td>
<td>12.5%</td>
</tr>
<tr>
<td>Columbian</td>
<td>1</td>
<td>6.25%</td>
</tr>
<tr>
<td>Venezuelan</td>
<td>1</td>
<td>6.25%</td>
</tr>
<tr>
<td>Indigenous (Mixteco)</td>
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<td>6.25%</td>
</tr>
<tr>
<td><strong>Highest Level of Education</strong></td>
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</tr>
<tr>
<td>High School</td>
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<td>25%</td>
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<tr>
<td>Associate’s Degree</td>
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<td>6.25%</td>
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<tr>
<td>Undergraduate</td>
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<td>12.5%</td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>6</td>
<td>37.5%</td>
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<tr>
<td>Doctoral or professional degree</td>
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<td>18.75%</td>
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<tr>
<td><strong>Mean</strong></td>
<td></td>
<td></td>
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<tr>
<td>Years Working with Latina Mothers</td>
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<tr>
<td>Years</td>
<td>13.78</td>
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</table>
Table 2.

**Experience of Depression**

<table>
<thead>
<tr>
<th>Theme</th>
<th># Participants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Isolation/Lack of Support</td>
<td>15</td>
<td>94</td>
</tr>
<tr>
<td>Identity During Acculturation</td>
<td>13</td>
<td>81</td>
</tr>
<tr>
<td>Immigration Status</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Presentation of Symptoms</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Role Expectations</td>
<td>11</td>
<td>69</td>
</tr>
<tr>
<td>Benefit of Group Interaction</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>Political Climate</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Domestic Violence</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Language</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Lack of resources</td>
<td>6</td>
<td>38</td>
</tr>
<tr>
<td>Discrimination</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Fear</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Employment</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>SES</td>
<td>5</td>
<td>31</td>
</tr>
<tr>
<td>Interpersonal Strain</td>
<td>4</td>
<td>25</td>
</tr>
<tr>
<td>Trauma during immigration</td>
<td>4</td>
<td>25</td>
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</table>
Table 3.

**Identification and Treatment Barriers**

<table>
<thead>
<tr>
<th>Theme</th>
<th># Participants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Knowledge of Depression</td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Insurance/Cost</td>
<td>16</td>
<td>100</td>
</tr>
<tr>
<td>Stigma</td>
<td>15</td>
<td>94</td>
</tr>
<tr>
<td>Trust and Safety</td>
<td>13</td>
<td>81</td>
</tr>
<tr>
<td>Language</td>
<td>13</td>
<td>81</td>
</tr>
<tr>
<td>Lack of relationship with provider</td>
<td>13</td>
<td>81</td>
</tr>
<tr>
<td>Immigration Status</td>
<td>12</td>
<td>75</td>
</tr>
<tr>
<td>Access to Care</td>
<td>11</td>
<td>69</td>
</tr>
<tr>
<td>Navigating the System</td>
<td>11</td>
<td>69</td>
</tr>
<tr>
<td>Family Opinion</td>
<td>10</td>
<td>63</td>
</tr>
<tr>
<td>Knowledge of Resources</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Lack of Cultural Providers</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Religion</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Embarrassing Self or Family</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Logistics</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Education</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Political Climate</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Acculturation Issues</td>
<td>7</td>
<td>44</td>
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<tr>
<td>Focus on Family and Children</td>
<td>7</td>
<td>44</td>
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<tr>
<td>Role Expectations</td>
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<td>44</td>
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Table 4.

**Stigma**

<table>
<thead>
<tr>
<th>Theme</th>
<th># Participants</th>
<th>Percent</th>
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<tbody>
<tr>
<td>Seen as Crazy</td>
<td>15</td>
<td>94</td>
</tr>
<tr>
<td>Lazy/Not putting Forth Effort</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Against Role as Mother</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Mental Health in General</td>
<td>7</td>
<td>44</td>
</tr>
<tr>
<td>Medications</td>
<td>7</td>
<td>44</td>
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</tbody>
</table>
Table 5.

**Barriers for Service Providers**

<table>
<thead>
<tr>
<th>Theme</th>
<th># Participants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of rapport building</td>
<td>14</td>
<td>88</td>
</tr>
<tr>
<td>Culturally adapting treatment</td>
<td>11</td>
<td>69</td>
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<tr>
<td>Not enough Spanish speakers</td>
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<td>69</td>
</tr>
<tr>
<td>Processes</td>
<td>9</td>
<td>56</td>
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<tr>
<td>Cultural competence</td>
<td>8</td>
<td>50</td>
</tr>
<tr>
<td>Lack of funding</td>
<td>5</td>
<td>31</td>
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<tr>
<td>Compassion fatigue</td>
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<td>31</td>
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<tr>
<td>Insurance</td>
<td>4</td>
<td>25</td>
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<tr>
<td>Treatment Compliance</td>
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</table>
Table 6.

*Impact of Acculturation*

<table>
<thead>
<tr>
<th>Theme</th>
<th># Participants</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acculturation Status</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Collectivistic Culture</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Traditions/Values</td>
<td>9</td>
<td>56</td>
</tr>
<tr>
<td>Language</td>
<td>7</td>
<td>44</td>
</tr>
</tbody>
</table>