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Exploring the Use of Familismo to Manage Depression Among Elderly Latino Women

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Walden University
2020

Abstract

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by

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MSW, University of Houston, 2012

BSW, Lamar University, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

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Abstract

As the elderly population continues to increase in the United States, so does the concern of major depressive disorder. Despite the need to forcefully recognize and address depression among this age group, efforts have been docile and passive; many elderly individuals continue to go undiagnosed. With the increase of Latino population within the past and upcoming decades and with studies showing that elderly Latinos appear to live longer than non-Latinos, it is critical that differences in treatment interventions be explored. This study aimed to explore the use of familismo (intense importance and attachment the Latino culture places on nuclear and extended family) as a coping skill to manage major depressive disorder among Latino women between the ages of 50 and 75. Purposeful sampling served as the method for selecting individuals who meet inclusion criteria. Eight individuals participated in the study. Sixteen interview questions were asked to explore family inclusion in treatment and the influence of concepts of familismo on how selected individuals cope with major depressive disorder. To promote health and well-being, 7 participants utilized emotion-focused coping and family inclusion throughout their treatment. One participant adhered to the use of familismo by not disclosing diagnosis to family. Exploration of participants indicated that Latino women utilize emotion focused coping to implement concepts of familismo to cope with major depressive disorder. This study was an effort to inform mental health professionals on effective interventions.

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Dedication

I dedicate this dissertation and the hard work put in throughout my PhD journey to my parents, David and Rocio Ramos. Mom and Dad, thank you for your unconditional love and patience. Everything I am is because of you. Thank you for coming along this journey with me and accompanying me on my professional and personal growth. Thank you both for all your sacrifice. Mom, thank you for being my rock, my "therapist", my friend and always ensuring that I am okay. Dad, you are the backbone of this family. Thank you for always prioritizing us but mostly thank you for working so hard every day to make sure we are protected and provided for. Dad, thank you, thank you for being the most amazing father anyone could ask for. Every day you show us what hard work truly is. You are the source of my inspiration and bravery. Without both of you in my corner, none of this would be possible. This is for you mom and dad! We did it!!

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Chapter 1: Introduction to the Study

Problem Statement

Untreated mental illness can have a negative effect on an individual's life, affecting physical health, employment, independence, and overall quality of life (National Alliance on Mental Health, n.d.). Individuals with mental illness often must negotiate both public and self-stigma, which perpetuates stereotypes, prejudice, and discrimination (Rüsch, Angermeyer, & Corrigan, 2005). Within the past decade alone, mental illness has become more stigmatized, as the general public often perceives individuals with mental illness as dangerous and incompetent (Rüsch et al., 2005). Public stigmas and stereotypes often perpetuate self-stigma, which causes some individuals to refrain from seeking mental health services or fail to continue mental health treatment (Rüsch et al., 2005). When mental illness is left untreated, individuals can begin experiencing consequences such as rapid decline in physical health, a full range of symptoms associated with their diagnosis, and stability issues such as unemployment or homelessness, trauma, or suicide (De Guzman, Woods-Giscombe, & Beeber, 2015).

Stereotypes and emotional reactions are different among ethnic groups (Rüsch et al., 2005). In the Latino community, only 1 in 20 individuals seek mental health care services (Alegia et.al., 2002; Berdahl & Torres-Stone, 2009). These disparities may be due to various elements such as cultural factors such as *familismo* (Alegia et.al., 2002). *Familismo* refers to the intense importance and attachment the Latino culture places on nuclear and extended family to identify self within the dynamic; attributes include loyalty, unity, cohesion, and mutual benefits (Villatoro, Mays, & Morales, 2014). The

problem is that, with a projected increase of 15.5% in the upcoming years, elderly Latinos represents a fast-growing population, and with this increase come high rates of psychological concern, particularly among women where depression rates rank alarmingly high (Shim,Compton, Rust, Druss & Kaslow, 2009). Most research has focused on younger Latinos transitioning to various milestones in life. At this time, current research often excludes samples with older Latinos, making this population underrepresented in literature (Alvarez, Rengifo, Emrani, & Gallagher-Thompson, 2014).

In this study, I explored the lived experiences of older Latino women diagnosed with depression to understand how they use culture concepts of familismo to cope. The disparities and underrepresentation of elderly Latinos in the mental health setting is a public health concern. It is critical to understand cultural concepts such as familismo to bridge the gap between elderly Latino women and compliance with mental health treatment by understanding effective ways to coping with depression. The results of this study will serve as a useful tool to identify effective ways professionals providing mental health services can implement, address or reinforce concepts of familismo to improve compliance as well as reconceptualize how elderly Latino women experience mental health treatment.

Purpose

The purpose of this phenomenological study was to explore the lived experiences of Latino women, aged 50 -75, who have been diagnosed with depression, and how they use familismo to cope with daily living. In this study, I explored elderly Latino women's views on how family support and cultural concepts of familismo help this population

cope with mental health. Individuals eligible to participate in this study were women between the ages of 50 and 75 who identify as Latino and have been diagnosed with major depressive disorder by a mental health professional. The study included the experience of eight individuals that reside in Houston, Texas. The study provides data and conclusions regarding how concepts of familismo help individuals cope with major depressive disorder and provides mental health professionals further insight into whether this is an effective intervention when working with this population.

Significance

The Latino community is the fastest growing minority group accounting for approximately14% of the U.S. population and is estimated to grow to 25% by 2050 (Ayon, Marsiglia, & Bermudez-Parsai, 2010; Kramer, Guarnaccia, Resendez, & Lu, 2009; Perez & Cruess, 2014). Among the Latino community, stigma and labels associated with mental health often stimulates this phenomenon of not seeking services (Ayon et al., 2010). Per Ayon et al. (2010), the fear of how mental health may disrupt their identity and potential loss of status often prevents Latinos from engaging in mental health treatment.

Untreated mental health illnesses can have numerous negative ramifications. Specifically, with Hispanic older women, mental health services are stigmatized although mental health stability is vital to their health (Rosales & Calvo, 2017). If left untreated, severity of symptoms experienced may worsen over time. Individuals who suffer from mental health disorders can develop issues with interpersonal relationships and others around them. The intention of the study was to assist mental health practitioners interpret

the appropriate method to utilize and implement family systems as a positive intervention to address major depressive disorder among Latino women, aged 50-75. Because family factors are usually the primary element aggravating depressive symptoms and since depressive symptoms are more prevalent among women, results are a critical tool in treating the condition (Vasilopoulos et.al., 2018).

Background of Problem

Mental health prevalence continues to rise, but only a small percentage of individuals seek assistance (Talebi, Matheson, & Anisman, 2016). A major barrier that prevents individuals from seeking professional help for their mental health needs is stigma (Corrigan, 2004; Talebi et al., 2016). According to the National Alliance on Mental Health (n.d.), roughly 1:5 adults in the United States will experience mental health illness, and Hispanics use mental health services at about half the rate of non-Hispanics.

As the Latino population continues to rise in the Unites States, the U.S. Department of Health and Human Services (2001) reports that it is critical to understand how family relationships within the Latino culture influence mental health treatment. Cheng, Wang, McDermott, Kridel, and Rislin (2018) noted that ethnicity affects and influences how individuals perceive mental health, their decision to seek assistance and what types of services the individual is willing to accept. There are many stigmas individuals must defeat when seeking mental health services. Among the Latino community, familismo is a critical factor in explaining why individuals may be apprehensive in seeking help. Families present as the primary carrier of cultural ideas

throughout generations and these connections influence individuals' behavior and understanding of concepts as it relates to illnesses (Martinez, Interian, & Guarnaccia, 2013). Because social support is critical for effective mental health treatment, familismo can often discourage help-seeking (Cheng et al., 2018; Martinez et al., 2013).

There is a hierarchical nature and dynamic within the Latino culture, and this social relationship usually includes concepts such as respect (Martinez et al., 2013). Understanding the value Latinos places on family is critical (Martinez et al., 2013) as the welfare of the group often takes priority over individual's well-being (Cheng et al., 2018; Martinez et al., 2013). Familismo often discourages help-seeking as individuals want to avoid placing a burden on their families, which often impacts the ill member in a negative way (Martinez et al., 2013).

Only a fraction of elderly individuals needing mental health care are actually receiving treatment (Vazquez & Clavijo, 1995). Vazquez and Clavijo (1995) reported that among those elderly, the Hispanic population are less likely to receive services due to language barriers, beliefs and concept of familismo. Significant barriers continue to deter Latino women from seeking adequate services. It is critical to explore relationship between mental health seeking and cultural concepts to improve outcome.

Hispanic Population in Houston, Texas, and Depression

With Hispanics constituting 41% of the population in Harris County in Houston, Texas, prevalence of mental health needs is high (City of Houston Department of Health and Human Services and Hispanic Health Coalition, 2013). Compared to 5.6% of whites, 7.9% of Hispanics reported severe psychological distress in Harris County, yet they

continue to underutilize mental health services due to the stigma associated with mental health, the fear of what society or other individuals may believe if made aware of the diagnosis, or simply feeling uncomfortable discussing their issues (City of Houston Department of Health and Human Services and Hispanic Health Coalition, 2013). Hispanics are at higher risk for depression and anxiety; furthermore, Hispanic women are at higher prevalence of depression accounting for 46% compared to Hispanic men at only 19.6% (City of Houston Department of Health and Human Services and Hispanic Health Coalition, 2013).

Mental Health, Depression, and Social Work

The World Health Organization (WHO, 2014) defined mental health as a state where an individual is in a position of well-being in which they are able to manage life stressors and confidently display their ability to complete work productively and efficiently in order to contribute to their community positively Mental health disorders include a wide range of issues with various symptomologies; however, it commonly includes a mixture of atypical thoughts, behaviors, emotions and interpersonal relationships (WHO, 2014).

The leading cause of disability around the world is depression, with more than 264 million individuals living with the diagnosis (WHO, 2014). This presents as an 18% increase from 2005-2015 (WHO, 2014). Depression is characterized by sadness that is persistent and low motivation in activities one previously enjoyed, along with difficulty completing daily living activities for more than 2 weeks (American Psychiatric Association, 2013). Additional symptoms of depression can include irregular sleeping

patterns, lack of energy, change in appetite, negative emotions such as guilt, worthlessness and thoughts of harming self or suicide.

Social work is a profession that assists individuals, families, groups or communities to "enhance or restore" their ability to function socially and assist in creating conditions to better meet their goal (National Association of Social Work [NASW], 1973). Per the NASW (n.d.), clinical social workers are the largest mental health providers in the nation helping individuals with various mental health diagnosis. Clinical social workers help individuals manage personal and social factors impairing their wellness and health (NASW, n.d.).

Theoretical Framework

The theoretical base for this study will be coping theory. Individuals with mental health illness often experience challenges that demands the use of coping skills. Coping theory can help assess individuals' ability to manage and address issues and evaluate how resources are used to readjust their behavior patterns (Hood & Carruthers, 2002). Coping theory can help evaluate how resources, such as family, are used to decrease the possibility of psychological distress. Coping skills help individuals manage external and internal demands by changing cognitive and behavior process, exploring coping responses is vital in mental health treatment (Hood & Carruthers, 2002). According to Hood and Curruthers (2002), psychological resources such as positive belief systems about self and others, such as family, can help alleviate negative response to triggers or stress, including symptoms of mental health illnesses. Social/family support and

connections are a significant resource and a major protective factor when coping with mental health illnesses.

Coping theory can help determine key concepts and strategies elderly Latino women utilize to directly confront stressors associated with depression. Coping theory can provide insight into whether concepts of familismo constitute an analytic approach in coping and regulating elderly Latino women's response to depression. Because depression can be considered a stressful process, coping theory can help determine consistent and effective strategies (O'Driscoll, 2013).

Research Question

The fundamental research question for this study is what are the lived experiences of Latino women, aged 50-75, who have been diagnosed with depression, and how they use familismo to cope with daily living?

Nature of the Study

The nature of this study will be qualitative. Specifically, I intend to conduct a phenomenological study, focused on participants' lived experiences. According to Priest (2002), a research design using a phenomenological approach requires collecting descriptions while preserving the spontaneity of subjects' experiences. Because phenomenological studies allow the researcher to explore the lived experiences and reality of the individuals, Priest (2002) reported that the most usual data source is verbatim transcripts of audiotaped interviews. I will conduct and record interviews. Priest also indicated that other sources are sometimes used, such as group discussions, written accounts, so I may use those in addition.

A phenomenological study, unlike other methodologies, will provide a subjective understanding and perspective of the lived experiences of the individuals (Larkin, Shar, & Flowers, 2018). A phenomenological study allows the exploration of this population's experience with depression, concepts of familismo, and the conscious use of coping skills and the phenomenon overall. This design assists in capturing the complex experiential phenomena as it gives insight into how an experience can be interpreted in various ways based on the interpretation and perception of the individuals (Larkin et al., 2018).

Intensive immersion is required to fully examine the data transcribed for each participant. Once transcribed, relevant statements are identified and compared to the next. Similar statements are grouped together (Priest, 2002). I followed this process with the data from all participants' interviews. Immersing myself in the study allowed me to explore the experiences of participants in regards to their understanding and use of culture to cope with major depressive disorder.

This study was focused on elderly Latino women and their experiences of familismo and coping with mental illness. Older Latino women who identify themselves as a member of a Latino ethnic subgroup (Mexican, Cuban, Puerto Rican, or South American), and who are between the ages of 50-75 were eligible to participate. To ensure confidence that results are representative, I selected a small, purposeful sample (see McLeod, 2008). In a phenomenological study, purposeful sampling, specifically criterion design, allows researchers to identify and select information-rich cases as participants have to meet a predetermined criterion (Palinkas et al., 2015). Specifically, older Latino women diagnosed with depression who attend senior center organizations such as nursing

homes, senior education centers, and senior activity centers, and who fit criteria, were selected to participate in one-on-one, semistructured interviews

Research Design

Eight participants were interviewed for this study. Interviews were held until saturation was reached. Saturation was achieved once now new themes emerge or are identified (Walker, 2012). I conducted one-on-one semistructured interviews with all participants. Interviews lasted approximately 60 minutes each. According to Ryan, Coughlan, and Cronin (2009), valuable insight and in-depth data collection can be gathered thorough one-on-one interviews as they can help researchers better understand each individual's perception, understanding, and experiences regarding the phenomenon being studied.

Key Elements of Data Analysis in a Phenomenological Approach

One-on-one interviews were held with elderly Latino women who meet criteria for participation. Participants were recruited by advertising the research opportunity in social media channels, specifically senior centers. Subsequently, asked participants for referrals. Compensation was provided for participants' time and effort. Incentives included a $10 gift card and non-monitory compensation such as food and drinks provided during interview. Throughout the interview, I asked questions regarding cultural concepts of familismo and mental health to further understand how familismo has influence their perception about depression and compliance. All interviews were recorded with the permission of each participant.

Definitions of Terms

Familismo: The intense importance and attachment the Latino culture places on nuclear and extended family to identify self within the dynamic; attributes include loyalty, unity, cohesion and mutual benefits (Villatoro et al., 2014).

Latino: A term to describe an individual of Latin American descent in the United States (Larson, Mathews, Torres & Lea 2017).

Major depressive disorder: A serious medical illness that impacts cognitive process, emotions and behavior in a negatively. The emotional and physical issues associated with depression can affect individuals' ability to function and symptoms can vary from mild to severe. Individuals must experience symptoms of depression for at least 2 weeks to be clinical diagnosed. Symptoms include depressed mood, anhedonia, change in appetite, irregular sleeping patterns, decrease energy, feeling hopeless, worthless or guilty, and/or thoughts of death and suicide (American Psychiatric Association, 2013).

Coping mechanism: Effective helping resources or processes used to reduce or counter the adverse consequences of a stressor or psychological distress (Singh, Raut, Subramanyam, Kamath, Pinto et al., 2014).

Assumptions and Limitation

Assumptions

The first assumption in this study was that the elderly Latino women diagnosed with major depressive disorder had, in some way, informed their family that they have a clinical diagnosis of major depressive disorder. Another assumption was that individuals

who met criteria would be accessible at locations previously stated and they would be willing participants in this research. Additionally, I assumed that all responses provided by the participants would be truthful as their experience and engagement were vital parts of this research. As the researcher of this study, I also assumed that I would be able to suppress all personal perception of the phenomena being researched and remain objective, only allowing for participants' perception as guidance.

Limitations

Potential limitations to this study include the ability to generalize to other cultures as this research primarily focused on the Latino populations. The study is also limited to a specific age group, those between the ages of 50-75; therefore, results may not be generalized to other age groups. An additional limitation is that because information obtained was through self-reports of sensitive and personal information, social desirability may have been present. As the interviewing process began, participants were encouraged to be honest and open throughout.

Summary

The percentage of elderly Latinos continues to rise rapidly as the Latino population continues to grow in the United States. Although depression is common within this population, only a low percentage seek out mental health services often due to the limited culturally appropriate services available (Alvarez et al., 2014). It is vital that mental health professionals comprehend the importance of how cultural factors can impact mental health treatment in Latinos. At this time, available studies often exclude

samples that include older Latinos therefore making this population underrepresented in literature (Alvarez et al., 2014).

Chapter 2: Literature Review

The prevalence of mental illness continues to rise in the United States with only a small percentage seeing professional assistance (Talebi et al., 2016). Although mental illness continues to be a concern there are many factors, such as stigma, that continues to present as a barrier to mental health treatment seeking (Corrigan, 2004; Talebi et al., 2016). Roughly 1:5 adults in the United States will experience mental health illness, and it is reported that Latinos use mental health services at half the rate of non-Hispanics (National Alliance on Mental Health, n.d.). The Latino population continuously underuses services, although they are two times more likely than Caucasians to experience depression within a given year (Stacciarini, 2009). With the Latino population rising in the United States, it is vital that barriers to mental health seeking are addressed.

The purpose of this phenomenological study is to bridge the gap in knowledge by focusing on how cultural concepts of familismo are implemented to cope with symptoms of depression among elderly Latino women. This research may promote social change by fostering and identifying effective ways to implement familismo in treatment plans when addressing coping skills to manage depression among this specific population. Results of this research can serve as a mental health resource when addressing this issue among mental health providers.

The goal of this literature review is to establish an association between use of coping skills and cultural concepts of familismo. This chapter will provide a comprehensive review with the primary focus being the utilization of cultural concepts of familismo as a coping skill to manage depression related symptoms. In the literature

review, I will discuss previous research specifically related to elderly Latino women, depression, and use of coping skills. Coping skills theory was used in this study to explore whether familismo is a positive and healthy coping skill to utilize in mental health treatment.

In this chapter, I offer an overview of the literature pertaining to depression among elderly Latino women, barriers regarding mental health seeking and concepts of familismo. At this time, there is a lack of prior research that addresses whether concepts of familismo are utilized to cope with depression among the elderly Latino population; therefore, this chapter will also focus on ideologies and perception that prevent Latinos from seeking mental health assistance.

Research Strategy

I performed this literature review using the terms *familismo, familism, Latino, elderly Latino women, coping skills, mental illness, depression, treatment for depression, elderly, geriatric, lived experience, older adult women, mental health services, Latino family, depression statistics* and *United States* in the Walden Thoreau multidata database. I also searched ProQuest, SocIndex, Sage Premier, Ebscohost, and PubMed. Only peer-reviewed articles were used for this literature review. Articles included were either written in English or translated into English in the database. Articles and text of the articles were reviewed, and only those that met inclusion criteria were utilized for this methodical review. Studies that focused on depression, Latina women, elderly who reside in the Unites States were used.

Coping Theory

Stress occurs when one perceives a type of incongruity between the physical and cognitive demands of an issue or situation (Baker & Berenbaum, 2007; Chen, Peng, Xu & O'Brien, 2018). Individuals respond and cope with stress in various ways. The effectiveness is subject to the type of stressor, the individual themselves, and the presenting circumstances. The ability to cope or coping style is a personality trait. Effort and the ability to effectively implement and utilize coping skills to manage stressful obstacles may change over time (Lazarus, 1993). Coping is a cognitive and behavior attempt to control demands that can stress an individual. Lazarus (1993) explained that there are two functions within the coping process: problem focused and emotional focused. Therefore, coping is based on what the individual is thinking and what they are doing to cope with issues dysregulating them. Coping refers to the cognitive and behavior acts individuals implement to manage a stressful issue or situation (Chen et al., 2018).

Brief History

Although coping has always existed, it was not until the 1960s and 1970s that it was formally introduced as a concept when researching stress (Lazarus, 1993). There are two theories that represent approaches to stress. The first is Hans Selyes theory of systematic stress which focuses on physiological responses and Lazarus theory, which focuses on psychological stress (Tan, Yip, 2018). In 1980, Lazarus (1993) and colleagues developed "Ways of Coping," which measures a series of predicates that portray the thoughts and actions individuals engage in when stressed. In 1989, a multidimensional

coping inventory was developed to assess the various ways individuals respond to stress (Carver, Scheier, Weintraub, 1989).

In 1960, theory of stress was introduced by Hans Selye (Tan, Yip, 2018). Stress is viewed as "a significant life event or change that demands response, adjustment, or adaptation." Stress is experienced as positive (eustress) or negative (distress). In 1956, Hans Selye depicted that stress is a physiological response pattern (Tan, Yip, 2018). This dependent variable incorporates three major notions:

- Stress is a defense mechanism.
- Stress includes alarm, resistance, and exhaustion stages.
- Prolonged or severe stress can cause severe outcomes such as diseases of adaptation or death.

The sympathetic nervous system is initiated to combat or avoid stress when one is challenged with a negative stimulus (Chapman, Tuckett, Song, 2008). This causes the physiological system to go into a fight or flight reaction to the stressor. Inability to return to a homeostasis state can cause harm such as mental illness (Chapman, Tuckett, Song, 2008).

Change and life events can have a grave impact on an individual. To better explain the process, Lazarus identified stress as a matter between an individual (including various systems) and their complex environment (Tan, Yip, 2018). Lazarus and Folkman (1988) explained that how individuals view a stressor and whether they believe they have adequate resources will ultimately determine how the individuals cope or respond to the stressor. Lazarus developed the transactional theory of stress and coping to inform how

stress is a dynamic process. According to this theory of stress, first there is a stressor, which is followed by primary appraisal (i.e., the individual determines whether the stressor is a treat), secondary appraisal (i.e., evaluation of resources), and coping response.

The transactional model of stress and coping that Folkman and Lazarus (1980) developed suggested that age is a factor in the difference in coping strategies implemented by individuals. This may be due the changes in what individuals deal with as they age (Folkman & Lazarus, 1980). Folkman and Lazarus proposed that, as one ages, different stressors are encountered and these stressors at that particular age influence coping approaches and health outcomes.

Coping Strategies

Problem-focused coping. There are five distinct aspects of problem-focused coping: active coping, planning, suppression of competing activities, restraint coping, and seeking of instrumental social support (Carver, Scheier, & Weintraub, 1989). Problem-focused coping aims at problem solving or taking actions to alter the source of the stress (Carver, Scheier, & Weintraub, 1989). Problem-focused coping skills involves the individual's determination to amend or change the presenting issues and can include strategies such as creating various possibilities to solve the problem at hand, assessing pros and cons regarding different outcomes that may arise and implementing action plan to solve the issue (Baker & Berenbaum, 2007). Problem-focused coping utilizes practical methods to target the trigger causing stress and to directly lessen or diminish the stress.

Additional strategies aimed at decreasing the stress can include time management and procuring a vital social support (Carver, Scheier, & Weintraub, 1989).

Baker and Berenbaum (2007) indicated that problem-focused coping generates the best outcomes because it addresses the main source of the issue and provides long-term positive results. Upon critical evaluation of the use of problem-focused research, on occasions such as bereavement or dealing with emotional responses, problem-focused strategies may not be as helpful. According to Baker and Berenbaum, in situations where the individual has no control over the stressor, problem focus will not be effective. Problem-focused coping is more effective when stressors can be controlled, such as exams or work-related stressors.

Emotion-focused coping. Emotion-focused coping encompasses the individuals attempt to diminish negative emotional responses triggered by the stressor. Negative emotions associated with the stressor included depression, anxiety, fear and frustration. There are five scales that are viewed as emotion-focused: seeking of emotional social support, positive reinterpretation, acceptance, denial and turning to religion (Carver, Scheier, & Weintraub, 1989). This concept aims at reducing or being able to manage emotional distress associated or triggered by the stressful circumstance (Carver, Scheier, & Weintraub, 1989). Emotion-focused coping is the management of emotional distress related to the presenting situation. Emotion-focused approaches are broad and can include tactics such as denial, fixating, and venting about emotions, reframing negative events for a more positive interpretation and seeking out support system (Baker & Berenbaum, 2007). Baker and Berenbaum (2007) reported that the validity and effectiveness of

emotional-focused coping will be contingent to the specific type of strategy employed by the individual.

Emotion-focused coping can also be referred as passive coping as this style is most often used to address the emotional responses to the issue (Hood & Carruthers, 2007). This coping style is selected when the individual feels a loss of control regarding situation or perceives that there is little they can do to modify the situation. Techniques used in emotion focused coping includes meditation, alcohol or drug use, journaling, distraction, emotional disclosure or praying (Hood & Carruthers, 2007).

Past studies have indicated that emotion-focused coping is maladaptive and ineffective. Baker and Berenbaum (2007) reported that individuals should be skeptical of existing research regarding emotion-focused coping because this type coping is often confused with distress, and although emotion-focused coping may appear to encourage avoidance, other techniques encourage approach. As it relates to health outcomes, studies have shown that emotion-focused coping does not generate useful outcomes as it ignores the room source of the trigger or stress. Baker and Berenbaum (2007) reported that emotion-focused coping did not create long-term solutions and in fact, the delayed response to addressing source of stressor caused negative effects within the individual. Research has also showed that women are more inclined to utilize emotion-focused coping than men are.

Techniques

Positive and active coping. The use of effective coping mechanism can help individuals' emotional welfare and mental stability. Individuals experiencing traumatic or

challenging situations can readapt thought the use of positive and productive coping methods (Rodríguez, Kozusznik, Peiró, & Tordera, 2019). Through positive coping mechanisms, individuals can reduce the likelihood of experiencing mental health issues such as anxiety and depression. Adaptive coping skills include talking to a support system and seeking external reinforcement from love ones, relaxation techniques such as meditation, muscle relaxation, or self-soothing techniques such as listening to music, humor, or physical activity (Rodríguez et al., 2019).

Positive coping can help reduce stress and improve one's ability to manage the problem at hand. Reframing one's perspective regarding the issue as a chance for changes versus a problem, it provides the individual with an opportunity not only mature but accepting faults without self-blame (Rodríguez et al., 2019). Active coping implies the individual's awareness of the problem perpetuating stress and making a conscious effort to address, reduce or eliminate the source.

Negative and avoidant coping. Research suggested that emotion-focused coping tactics are correlated to maladaptive strategies and can cause mental health issues such as depression and anxiety (Chen et al., 2018). Negative coping can provide immediate relief from the pain and stress but over time cause further challenges (Grant et al., 2013). Maladaptive coping skills can include risk-taking behavior and compulsions, self-harm, isolation, withdrawing from family and friends, and unhealthy habits such as overeating, drinking or excess use of internet (Chen et al., 2018; Grant et al., 2013).

Avoidant coping is the individual's lack of active effort to change the stressor. This maladaptive form consists of the individuals' purposeful and decisive modification of

behavior to avoid feeling or thinking of undesirable issues (Grant et al., 2013). Instead of coping with the stressor, avoidant coping focuses on shunning away. Although avoidant coping does not necessarily have to be associated with awareness of the stressor, it simply implies the individuals lack of action in attempting to eliminate stressor (Grant et al., 2013).

Summary of Coping

Even though the most stressful situation evokes the use of both types of coping, according to Carver et al. (1989), problem-focused coping is predominately used when individuals feel that a constructive action can be taken whereas when individuals feel as the stress should be endured, they elicit emotion-focused coping. Distinguishing the difference between problem-focused and emotional focused coping is vital. The majority of research concluded women have a higher success rate in addressing issues when emotional focus coping is utilized versus men who are more successful when utilizing problem-focused coping (Baker & Berenbaum, 2007). In order to determine the effectiveness of coping strategies, it is critical to understand and assess the context of the situation.

The success of the coping approach implemented is not related on whether problem-focused or emotion focused was utilized but rather the coordination between the presenting situation and the individual's ability to apply the strategy (Hood & Carruthers, 2007). In simplicity, problem-focused coping implicates the individual's effort to modify the individual-environment transaction while emotion focused coping centers on regulating distressing emotions associated with the issue (Chen et al., 2018). There is

extensive literature that shows individual's ability to evaluate and cope with a situation can affect stress and depression (Johnson, Gooding, Wood & Tarrier, 2010).

Major Depression Disorder

What is Depression?

Major depressive disorder or clinical depression is a serious mental health disorder that is common. Individuals who experience major depressive disorder endure feelings of persistent sadness or hopelessness and often lose interest in activities once enjoyed (Belmaker & Agam, 2008). Along with emotional issues, depression can often cause individuals to suffer from physical symptoms such as chronic pain or digestive problems (Belmaker & Agam, 2008).

Major depressive disorder is known as a unipolar disorder. This means that the lows, or negative emotions and symptoms individuals experience, are the sole focus (Lieber, n.d). The characterization of unipolar signifies that difference between major depression and bipolar depression which is a fluctuation between depression and mania (Lieber, n.d).

Diagnostic Criteria

According to the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), in order to meet criteria to be diagnosed with major depressive disorder individuals must be experiencing five or more of the following symptoms during the same 2-week period and at least depressed mood or loss of interest or pleasure should be experienced. According to the DSM-5, symptoms includes:

- Depressed mood most of the day, nearly every day.

- Markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day.
- Significant weight loss when not dieting or weight gain, or decrease or increase in appetite nearly every day.
- A slowing down of thought and a reduction of physical movement (observable by others, not merely subjective feelings of restlessness or being slowed down).
- Fatigue or loss of energy nearly every day.
- Feelings of worthlessness or excessive or inappropriate guilt nearly every day.
- Diminished ability to think or concentrate, or indecisiveness, nearly every day.
- Recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide.

Associated Features

Major depressive disorder has numerous associated features. An individual suffering from depression can exhibit or display extremely grave warning signs such as suicide attempts or express verbal markers suggesting suicide ideation (Serra et at., 2015). Individuals experiencing mild depression can present with features that include crying spells, irritability, mood swings, restless behavior, excess worrying, phobias and obsessive rumination on the past or future (Serra et at., 2015). Additional antecedents of depression can include insomnia, low self-esteem, academic decline, somatic symptoms, impulsive behavior and substance abuse (Serra et at., 2015).

Types of Depression

Depression has many types, according to Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5). Types includes: Major Depression, Bipolar Depression, Cyclothymic Disorder, Dysthymic Disorder and Seasonal Affect Disorder.

Major depression. Major depression can be used interchangeably with depression, clinical depression, unipolar depression or major depression disorder. Symptoms of major depressive disorder can be experienced most days in a two-week-period. Symptoms often inhibit personal, professional or social life. The three levels to describe depression are mild, moderate or severe.

Melancholia. Melancholia is a severe form of depression which most physical symptoms are present. Anhedonia is more commonly present in melancholia depression which is the loss of pleasure of almost everything that use to bring pleasure to the individual. Psychotic depression is when the individual experiencing depression loses touch with reality and begins to experience psychosis which can include hallucinations (auditory or visual), delusions (false believes) or paranoia (feeling as everyone is against you and they are directly causing the illness). Antenatal and postnatal depression often occur to women during pregnancy. Women can experience these symptoms immediately after birth due to hormonal changes. This type of major depression does not only affect the mother but her connection and bond with the baby. If not treated it can affect the child's development and the mother's interpersonal relationship with others such as spouse and family members.

Bipolar depression. Bipolar disorder is a mental health disorder that is characterized by manic, hypomanic and depressive periods. One-two percent of the world population is diagnosed with bipolar disorder (Gilkes, Perich & Meade, 2018). The primary and most common indicator of bipolar disorder are depressive episodes (Diler et al., 2017). Diler et at. (2017) reported that studies advise that atypical depressive indicators such as increased appetite and increase sleep along with leaden paralysis and psychomotor delays are common symptoms of bipolar depression compared to major depressive disorder.

Cyclothymic disorder. According to Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), cyclothymic disorder is when an individual fluctuates in moods for a period of two years. This involved short periods of hypomania and depressive state with shorter durations of symptoms. Symptoms are also less severe and irregular therefore it is often described as a milder form of bipolar depression. Due to the duration or intensity of symptoms, it does not meet criteria for depression or bipolar depression.

Dysthymic disorder. Dysthymic disorder is a persistent depressive disorder. According to *Diagnostic and Statistical Manual of Mental Disorders*, 5th Edition (DSM-5), dysthymia is continuous and a long-term form of depression. Individuals diagnosed with dysthymia experience symptoms for years and symptoms significantly impact professional and personal activities. Individuals experiencing dysthymia disorder have difficulty being positive, cheerful or optimistic and are often described as having a

melancholy personality. Symptoms of dysthymic disorder typically last for more than two months and major depression episodes beforehand or during a dysthymic episode.

Seasonal affective disorder (SAD). The Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5) refers to seasonal affective disorder as a depression with a seasonal pattern related to the differences in light exposure in the various seasons. Although the cause of the disorder is uncertain, individuals diagnosed with seasonal affective disorder experience mood disturbances at the beginning or ending of a particular season. The most common seasonal depression is the start of winter with symptoms diminishing as winder comes to an end; SAD is diagnosed if the individual experiences this pattern for a couple of years.

New Specifiers for Depression in DSM-5

In the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, the DSM-5, two specifiers were added to further classify diagnosis:

1. With mixed features
2. With anxious distress

The with mixed features specifier indicates that the individual does not meet full criteria for manic episode, but manic symptoms are present as part of the diagnosis of depression. Mental health providers can indicate “with anxious distress” when prognosis, treatment interventions and individual’s response to treatment is affected by anxiety. If this occurs, mental health providers are required to assess whether the individual presents with anxiety along with depression.

Depression Versus Sadness

At times, it can be difficult to distinguish depression from sadness since sadness is the primary symptom (Shelton, 2018). Although both are psychological states, the primary differences are the combination of factors. Shelton (2018) reported that the duration of the negative feelings, impact on physical state and how these factors impact one's ability to function daily are primary differences between sadness and depression. While sadness will be experienced by everyone because it is often caused by a specific trigger, be it situation event or person, with depression no specific trigger is necessary. Depression can induce feelings of hopelessness regarding various aspects of individual's life even though they may have reason for happiness. These individuals often do not have the capacity to fell joy.

Additional differences between depression and sadness is duration, sleeping and eating patterns. When experiencing sadness, this emotion may last days but individuals continue to enjoy things such as being with friends and family. However, with depression one might not enjoy activities that used to be pleasurable. Individuals with depression may also present with serious disruption in their daily living. Lastly, individuals with depression may experience suicide ideation that are often not seen in sadness. Depression can cause or induce thoughts of self-harm or suicide or cause individuals to develop suicide plan.

Depression in Elderly

Even though major depressive disorder is a widespread issue among the elderly, it is not a function of aging (Ciasca et. al, 2018). With the elderly population growing in the

nation, concerns regarding how major depressive disorder impacts these individuals arise. An average of 6 million elderly individuals are affected with depression but only 10% will receive mental health treatment (Hoertel et. al, 2013, Dong et. al., 2018). Therefore, major depressive disorder continues to be underrated among this population (Hoertel et. al, 2013). Dong et al. (2018) reported that the elderly population are more prevalent and are at higher risk to meet criteria for major depressive disorder which includes grave outcomes such a suicide. Depression affects elderly different than younger adults. Dong et al. reported that depression among the elderly most often ensues medical illnesses and long-lasting disabilities.

The significantly increased disparities among this group compared to other age groups is grave as depression in elderly is linked to outcomes such as death because symptoms of depression can perpetuate illness and not allow for individuals rehabilitation (Clignet, Van Meijel, Van Straten, Lampe, & Cuipers, 2012). Due to diminished physical capabilities, depressed elderly decrease engagement in activities or social interaction that is vital to maintain good health (Clignet et al., 2012). The National Institute of Mental Health (n.d) reported that depression among individuals over the age of 65 is a chief public health concern. Among the elderly, major depressive disorder can be disabling and may cause potential serious and negative outcomes which includes cognitive and functional impairments (Breno & Charles, 2014). Depression continues to be one of the most dominant mental health diagnoses among the elder population, including ethnic and racial groups. This diagnosis is a primary burden amongst diseases and disabilities in the

United States. Significant number of individuals among this age group continues to be undiagnosed and untreated.

Depression Among Older, Latino Women

Significant major depressive disorder symptoms commonly affect the elder population. Barry, Allore, Guo, Bruce, and Gill, (2008) reported that although 1 to 2% of the elderly population meet criteria to be clinically diagnosed with major depressive disorder, 8 to 20% of elderly individuals will experience depressed mood or depression. Depression is disproportionately high among elderly women than elderly men. Elderly women are often burdened with depressive symptoms (Barry et al., 2008). Barry et al., (2008) reported in their study that older women are more likely to obtain and comply with pharmacologic and psychotherapeutic treatment than men, yet women continue to be at higher risk for depression and prehospitalization. Due to the fact that they are more likely to seek treatment, they are less likely to die when depressed.

Risk factors associated with onset of depression among elderly women includes poor self-esteem, feeling of hopelessness and social economic status. These elements increase the threat of depression among this group (Barry et al., 2008). Among older Latinos, the female gender is at higher risk for depression than their counterparts (Brennan, Vega, Garcia, & Abad, 2005). Amid older Latino women, there are numerous disparities in the acknowledgment and management of major depressive disorder (Sadule-Rios, Tappen, Williams, & Rosselli, 2014; Barry et al., 2008). Past studies have shown that depression among minorities compared to White non-Hispanics differ and suggest that older Latinos have the highest rate of depression. Sadule-Rios et al. (2014)

reported that discrepancies among this group is due to lack of access to care, delays within the medical system which results in mental health care delays and treatment. These delays have resulted in grave outcomes as decline in treatment has been associated with high rates of suicide within this minority group.

Within the Latino population, avoidance in treatment is a barrier as stigma continues to be associated with mental health disorders and mental health seeking. Sadule-Rios et al. (2014) reported the importance of utilizing catch-all words or phrases to tolerate inclusion of these individuals because elderly Latinos were less likely report mental distress when diagnostic jargon was used. Sadule-Rios et al. (2014) reported that even if Latinos seeking treatment, more than half will still go untreated and those treated are less likely to be treated with psychotherapy services. Compliance overall with treatment is low.

An additional barrier in past studies have identified the cultural variation in Latinos perceive depression and how they report symptoms to their primary care physicians. Lack of adequate reported symptoms and cultural idioms used to describe symptoms results in undiagnosed disorders (Sadule-Rios et al., 2014). Shattell, Smith, Quinlan-Colwell, and Villalba (2008) reported that only 24% of elderly Latina women compared to 34% of white older women will receive the appropriate mental health care required to maintain stabilization. Subgroups within the Latino culture require specific needs due to their unique demographic traits which may include immigration status, educational level, social economic status and employment status (Shattell et al., 2008; Sadule-Rios, Tappen, Willliams & Rosselli, 2014).

Within this culture, it is vital to address the influence family roles and responsibilities play in mental health seeking and treatment engagement among the individuals. Shattell et al. (2008) discussed the importance of Latina women putting the wellbeing of their family and children first and are most likely to fear seeking mental health assistance to avoid feeling useless. Their study found that Latino women placed family in the forefront and engaged in holistic treatment to meet their emotional, physical, spiritual and mental health needs. Latina elderly women are inseparably enmeshed with their family and any barrier or factor that dysregulates dynamic or discords family function can trigger emotional distress, including depression.

No further literature was found which focused directly on major depressive disorder and specifically elderly Latino women. There is substantial information regarding barriers to services and numerous studies that focus on lack of mental health service availability and lack of access to appropriate mental health services. Studies that focus on mental health and how the elderly women cope with depression utilizing concepts of familismo continues to be lacking.

Treatment for Major Depressive Disorder

The exact cause of depressive disorders continues to be unknown but Shelton (2018) reports that causes may include biological distinctions, brain chemistry, hereditary traits or life affairs. Due to the fact that the exact cause is unknown, major depressive disorder can be treated via a combination of psychiatric medication and talk therapy. Mental health practitioners assess for treatment approach based on various factors such as severity of indicators, ability and desire to address triggers that may induce emotional

distress, treatment individual previous engaged in, toleration of medication and personal preference (Kennedy, Lam, McIntyre et. al, 2016). Antidepressant medication can include selective serotonin reuptake inhibitors (SSRI's), Tricyclic antidepressants (TCA's) and serotonin and norepinephrine reuptake inhibitors (SNRI's) (Kennedy, Lam, McIntyre et. al, 2016)

Psychotherapy or psychological counseling is often recommended by mental health providers to effectively address conditions and issues perpetuating depression. Mental health professionals engage in various types of psychotherapy such as cognitive behavior therapy (Jakobsen, Hansen, Storebo, Simonsen, & Gluud, 2011). This approach can help individuals adjust to the presenting crisis, identify problems that cause the depression or modify behavior that perpetuate these factors, identify effective ways to cope and problem-solve, address and change negative believes, and learn to establish healthy goals in life (Jakobsen et al., 2011).

Stigma

Conner et al. (2009) defined stigma as negative attitudes, beliefs and views regarding mental health. These stigmas, whether by the individual themselves or by society, can become a barrier to help in seeking and treatment concerning their mental health diagnosis. The primary reason individuals refrain from seeking mental health treatment is stigma (Conner et al., 2009). The National Alliance on Mental Health (2009) informed that individuals or families may not seek mental health treatment, due to stigma, but additional reasons may include shame, cost of treatment, distress, fear of

being chastened and social stigmas. Stigma discouraged the individuals from receiving the needed interventions to appropriately address mental health disorders.

Utilizing data from a multicomponent research conducted by Jimenez, Ryenolds, Alegria, Harvey, and Bartels (2015), it was founded that older Latinos have high prevalence of depression and anxiety and majority met full Diagnosis and Statistical Manual criteria for diagnosis. This study also found that there is inadequate geriatric mental health specialist who are unable to appropriately meet the needs of the Latino elderly population. Even though this vulnerable population often presents with dual diagnosis such as physical and mental health issues, the increase stigma associated with treatment such as pharmaceutical intervention and talk therapy prevents help seeking (Jimenez et al., 2015). Jimenez et al. (2015) reported a need to develop effective preventive interventions to older Latinos who are diagnosed with mental disorders such as depression. Amidst the rapid demographic growth, Jimenez et al. (2015) discussed the need to promote culturally relevant interventions as their study found that mental health services continue to be highly stigmatized within this racial/ethnic groups.

Christensen, Griffiths, Barney, and Jorm (2009) evaluated stigma linked with depression. The study investigated whether community perception of mental health, specifically depression, attributed to individual's reluctance to seek mental health treatment. Their study found that individuals were less favorable to seeking mental health treatment due to fear of being scorned or ridiculed by family, friends and colleagues. This study found that individuals diagnosed with depression feared that loved ones in treatment may be considered less favorable. In the focus group held with 23 adults, where

personal experiences were discussed, it was founded that individuals also reported concerns that general practitioners and mental health specialist would also think negatively if depression was discussed. It was concluded that stigmatizing ideas and beliefs regarding depression, whether perceived or real, has a significant effect on individuals diagnosed with depression.

Christensen, Griffiths, Barney, and Jorm (2009) notified that many individuals believe that others hold negative perceptions regarding depression and help-seeking and would think that depression signified weakness. They also found that most feared being thought of as weak, lazy, powerless, incompetent and inferior. Christensen, Griffiths, Barney and Jorm (2009) found that stigma prevented the individual from disclosing depression to their support system such as family, friend and colleagues as well as other forms of help seeking professionals.

Latinos in the United Stated: Overview

According to the U.S. Census Bureau (2010), Latinos will make up 30% of the United States population by the year 2050, making Latinos the largest minority population. The Latino population consists of ethnic groups which includes South and Central Americans, Mexicans, Cubans and Puerto Ricans (Berdahl & Stone, 2009).

In 1873, the financial panic led to anti-immigration policies and fundamental changes (Martinez-Brawley & Zorita, 2018). Due to the need of labor workers, immigrants were allowed to remain in America and do undesirable employment Americans did not want to do (Martinez-Brawley & Zorita, 2018). When the Mexican Revolution erupted in 1910 and then World War I, it created a labor shortage in the

United States, consequently Mexicans who remained after the Mexican Revolution were encouraged to work in the USA (Martinez-Brawley & Zorita, 2018).

It was not until 1930 that Mexicans were counted in the US Census which also identified them as a mixed group primarily belonging to the labor class. In 1968, the Western Hemisphere capped the number of Mexican applicants seeking visas, this measure was followed by numerous pieces of legislation that restricted legal entries to the United States of America from Mexico and Latin America (Martinez-Brawley & Zorita, 2018). Subsequently, due to the paradoxical nature of these immigration policies, it created a considerable number of undocumented Latino population in the United States (Martinez-Brawley & Zorita, 2018).

Immigration continues to be a recurrent narrative, especially as it relates to the number of Mexicans and other Latin Americans entering the United States (Martinez-Brawley & Zorita, 2018). There are numerous events that intensified the anti-immigration public feeling such as the 2001 attack economic crisis in 2008, that although was not related to Latinos, it reinforced overt anti-immigration views (Martinez-Brawley & Zorita, 2018). While there continues to be aggravated hostility towards immigrant population in the United States, Mexican and Latin American individuals residing in the United States continues to grow; particularly illegals.

In the United States, there was a reported 50.5 million individuals from Mexico and Latin America by the year 2010 (Martinez-Brawley & Zorita, 2018). Although this number may appear high, the Pew Hispanic Center (2011) reports that the number of immigrants entering the United States has declined stating that within the last decade, the

number dropped from 29.5 percent to 27.6 percent; mostly due to the Great Recession between 2007-2009. This decline did nothing to change the anti-immigration dialogue. Texas plays a vital role in influencing the attitudes on Anglos towards Mexicans (Martinez-Brawley & Zorita, 2018).

Cultural Concepts of Familismo

Family provides fundamental relationships and experiences which strengthen traits such as loyalty and trust. Family can bring individuals meaning as it provides a sense of belonging. Family comes in various sizes and shapes and although it is vital to mention that although not all families may offer a safe and secure environment, family is the primary source of support for individuals (Northway, 2015). Family, in the context of human civilization, is a group of individuals who are related either by consanguinity (by birth), affinity (by marriage or other related relationship such as adoption) or kinship (Driessnack, 2017). Driessnack (2017) explains that geographic heritage is not important when discussing family health but understanding who you are from is critical in identifying sense of self. Understanding intergenerational self and the connection beyond generations contributes to the way individuals manage life experiences and challenges as well as resilience is all stages of life (Driessnack, 2017).

Familismo, according to La Roche (1999), is defined as an individual's strong ties and connection to both their nuclear and extended families. Latinos present with high rates of familismo. Latinos have strong cultural values which its ideologies can present either as a barrier or support. The Latino culture presents with a strong family support. Per La Roche (1999), concepts of familismo can diminish outside support as individuals

in this culture have strong feeling of loyalty, solidarity and reciprocity toward family members. Familismo values provides key cultural scripts which have been associated with positive psychosocial outcomes in the Latino culture (Stein, Cavanaugh, Castro-Schilo, Mejia, & Plunkett 2018). These strong bonds can help assist individuals with mental health disorders cope with symptoms.

Familismo is a cultural construct that outlines vitality among the Latino culture and how family ties are prioritized (Hernandez & Bamaca-Cobert, 2016). Familismo emphasizes placing precedence on family members before individuals own needs (Hernandez & Bamaca-Cobert, 2016). Hernandez and Bamaca-Cobert (2016) informs that familismo is exhibited via bonding with family members, decision-making regarding family interest and sustaining cohesion. Extensive research analyzes that cultural socialization is used to pass familismo and cultural values from generation to generation (Hernandez & Bamaca-Cobert, 2016). Emotional support and beliefs about family loyalty are provisions of family support and often dictated by value of familismo (Stein et al., 2018). According to Stein et al. (2018) this includes having pride or feeling embarrassed by one's family.

There are numerous studies that address and focus on the importance of the connection of familismo values and positive affect. Feeling of happiness and feeling rewarded is a response to acting in a way that is coherent to values of familismo, therefore, looking via a lens of familismo can help predict positive psychological functioning (Stein et al., 2018). An aspect of pride, in accordance to familismo includes not bringing shame to the family and taking actions to bring honor and pride to the family

as well as feeling pride of one's own family (Stein et al., 2018). Individuals feeling of pride also motivates social behaviors in the Latino culture which is vital to address as seeking mental health services can dysregulate these emotions due to the stigma still attached to mental illnesses.

Familismo is a multilayered and complex construct that incorporates value endorsement such as attitudinal familismo and behavioral familismo (Stein et al., 2018). Researchers have classified the endorsement of family "as a source of emotional support, personal obligation to family needs and family as a referent when making decision" as attitudinal familismo (Hernandez & Bamaca-Cobert, 2016, p.463). Attitudinal familismo focuses on the value placed on family support and mutual support within the family structure (Hernandez & Bamaca-Cobert, 2016). A large construct critical to familismo is the importance of respect for parents and elderly.

Various accumulating studies suggest that, within the Latino culture, the most influential unit is family (Nicasio, Cassisi, Negy, & Jentsch, 2019). Compared to other cultural groups, Latinos endorse higher levels of familismo which validates the need to understand how familismo influences mental health outcomes (Nicasio, Cassisi, Negy, & Jentsch, 2019). Familismo values such as sense of pride in self and bringing pride to one's family are key aspects that will be examined as this helps promote adaptive and positive behaviors. In summary, the literature on familismo has not fully examined how cultural concepts of familismo is utilized as a coping skill among its member's, specifically elderly females. This study will seek to address elderly Latino women to

utilize the behavior and emotional mechanisms of familismo as a coping skill to manage symptoms of depression

Latino Population in Harris County

The U.S Census Bureau (n.d.) identifies Hispanic or Latino as an individual Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race (see Figure 1). The U.S. Census Bureau (n.d.) adheres to two ethnicity categories: Hispanic or Latino and Non-Hispanic or Latino and also reports that Hispanic origin and race are two distinct concepts suggesting that Hispanic and Latinos may be of any race. Therefore, the U.S Census Bureau does not add the Hispanic percentage in racial categories. In regard to origin, this is often viewed as a nationality group or country or birth of an individual or individual's parents/ ancestors prior to arriving to the United States (U.S. Census Bureau, n.d.).

Hispanic or Latino Origin

- Mexican
- Puerto Rican
- Cuban
- Dominican Republic
- Central American (excludes Mexican)
  - Costa Rican
  - Guatemalan
  - Honduran
  - Nicaraguan
  - Panamanian
  - Salvadoran
- Other Central American
- South American
  - Argentinian
  - Bolivian
  - Chilean
  - Colombian
  - Ecuadorian
  - Paraguayan
  - Peruvian
  - Uruguayan
  - Venezuelan
  - Other South American
- Spaniard
- All other Hispanic or Latino

Figure 1. Hispanic and Latino subgroups.

The Latino population makes up 43% of the population in Harris County (U.S Census Bureau n.d.). Within Harris County, the Latino population continues to grow making Latinos half of Texas population. Loeb (2017) reports that since 2010, Harris County has increased by 39,600 Latinos, making it the largest increase in the United States during this specific time period. According to the most recent census (2010-2016), while the population in Texas grew by 2.7 million the Latino population rose by 15% (Loeb, 2017). The African American population on rose by 13.8 percent and the white population only growing by 3.9 percent (Loeb, 2017).

According to the Pew Research Center, the nation's largest minority group are Latinos and it continues to grow with a projected population of 133 million by 2050, which will make it 30 percent of the overall population. Among the 60 counties in Texas, Harris County has the second largest Latino population following Los Angeles County, California.

Mental Health Needs Among Elderly in Harris County

In correlation with Latino's nature to remain family centered and seek assistance within the family, in Harris County, stigma continues to be a major obstacle in the treatment of major depressive disorder. According to the current national census held in 2010, older adults accounted for 8% of the Harris county population (US Census 2010, n.d). The 2010 census reported that elderly women accounted for 57% of the Harris county residents over the age of 65; which is a 1% increase from the previous census were elderly females accounted for 7% of the elderly population. The 2010 census also

informs that Harris County is one of the nations divorce communities. The 2010 census reported that Latinos made up 17% of the county's population of those 65 or older.

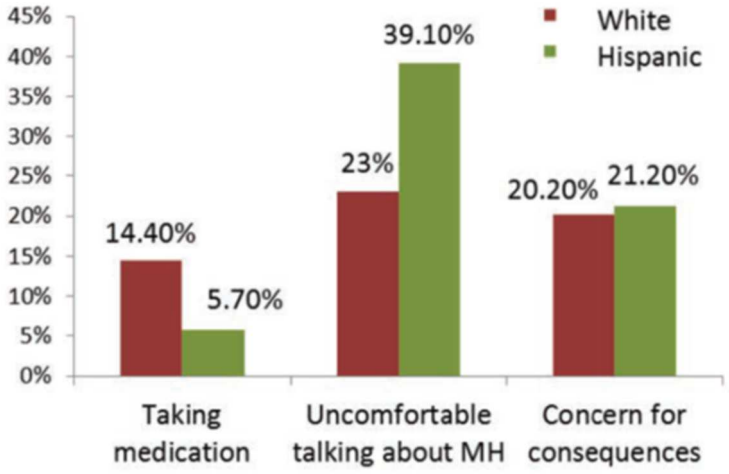

Figure 2. Mental health seeking in Harris County.

Researchers did not specify an exact percentage of elderly female Latinos presently diagnosed with depression in Harris County nonetheless, extensive information that analyzed the grave importance of understanding and addressing aging related issues; including depression. Due to the increase health needs of elderly population in Harris County, the Harris Health Systems were established. According to Harris Health Systems (n.d.), they address specific age-appropriate issues and provide treatment as needed. One health issue addressed included depression. Aging is an intricate process which affects social, mental, physical and spiritual development. Although the elderly population only accounts for 12% of the United States population, this population accounts for 20% of the nation's suicide with mental health issues being the primary cause (UT Health Systems, n.d.). In addition, UT Health Systems (n.d.) reported that the elderly population is more

reluctant to seek psychiatric treatment though research has linked depression with genetic changes and imbalances in chemistry.

Family Support and Mental Health

A characteristic of the Latino culture is the strong family ties; therefore, Latino patients tend to manage mental illnesses initially though the support of family members and cultural beliefs (Lopez & Castillo, 2001). Mental health services are generally sought out when family efforts are depleted. In the Latino culture, social support; primarily family support, is a critical source in the care of those suffering with mental illnesses and the psychological wellbeing of those members (Karno & Jenkins, 1993).

There are many studies that support that the use of familismo is associated with positive outcomes. Literature supported the belief that individuals were more inclined to seek and receive treatment regarding their mental health illness when they had positive interpersonal support. Support by mental health providers and individuals family highly influenced adherence to treatment. Family support affected individual's attitude towards mental health treatment.

Chapter Summary

Health care professionals would benefit from helping elderly Latino women learn how to effectively utilize family support within their own context (Urizar & Sears, 2006). Depression is a public health issue due to its obstructive outcomes amongst this population. Depression presents as a costly and dangerous issue that has grave negative consequences and prevalence among elderly Latino women needs to be addressed (Barry et al., 2008). Cultural differences and disparities result in older Latino women not being

properly diagnosed or continue to go untreated as perception of depression continues to be a barrier to treatment.

Despite the immense research conducted for this literature review, familismo as a coping skill is still not well comprehended by professionals in the mental health field. Literature also has shown that there continues to be a need on identifying effective coping skills to manage depression in order to improve treatment and outcome among older Latino women. Given that many are initially skeptical in seeking or receiving treatment mental health professionals should gain the knowledge needed to receive adequate help. To reduce risk factors for depression, it is vital to insure acceptable, applicable and efficient treatment.

Chapter 3 will contain instruments and questions that will be employed for the study. In Chapter 3, I will identify and explain in depth the design of the research methodology that will be utilized to execute the study. It will include a description on the criteria participants will need to meet to participate in the study as well as a description of various settings that will be used.

Chapter 3: Research Method

Introduction

In this dissertation, I explored the experiences of Latino women between the ages of 50 and 75 with respect to concepts of *familismo* and coping with major depressive disorder. I explored, coded, and analyzed themes regarding how cultural concepts of familismo are implemented to cope with depressive symptoms. Understanding individuals' experiences with mental health, specifically depression, can help determine how belief and attitudes, along with culture, can influence or affect outcomes. The goal of this research was to determine how concepts are implemented as coping skills to manage depression and if themes on the use of cultural concepts of familismo develop throughout this specific age group.

In this methodology chapter, I outline the qualitative research design selected, research question, and rational for the selected research strategy. This chapter includes a synthesis of the procedures I followed to recruit individuals for the study, how data were collected, instruments that were used, and the statistics and analysis plan. This includes the research question, tradition and rational for the chosen methodology. In this chapter, the role of the researcher is also identified, as is the population, sampling strategy, criteria participants needed to meet, number of participants, and specific ways in which participants were identified and recruited. I also include legal documentation for the data collection instruments used, source of the data collection tool, how the instrument was developed, and how validity was established. This chapter also includes discussions of

specific cultural issues. Data analysis and issues related to trustworthiness and ethical procedures are discussed in this chapter.

Research Design and Rationale

Qualitative research is an inquiry based on experiences, connections, and relationships (Padgett, 2016). Padgett (2016) reported that qualitative research is consistent with social justice and liberty of values as it stresses human action. Padgett (2016) stressed that, in a qualitative study, human activities are observed and interpreted. Qualitative studies respect human actions in the questions researchers asks, in the exploration stage, and how data and findings are presented.

In this study, I used a phenomenological approach. Implementing a phenomenological investigation promotes the understanding of the phenomena and provides insight into experiences, beliefs, emotions, thoughts, attitudes, and views of the individuals as it relates to the phenomena (Percy, Kostere, & Kostere, 2015). A phenomenological investigation can help capture the essence of the lived experience and the meaning individuals place on these experiences. (Percy et al., 2015). Because attitudes toward mental health seeking influence whether the individual is receptive to treatment, understanding individuals' cognitive processing is vital (Mackenzie et al., 2008; Percy et al., 2015).

In this study, using a phenomenological approach allowed me to explore the lived experiences of elderly Latino women between the ages of 50 and 75 in regard to how they utilized cultural concepts of familismo in coping skills to manage symptoms of major depressive disorder. Phenomenological research has strong philosophical origins

which help to understand human experiences (Wilson, 2015). Phenomenological researchers intentionally study human consciousness by collecting detailed data about not only the individual's experience but also how they interpret, perceive, and feel about the experience (Ungvarsky, 2018). Ungvarsky (2018) suggested that no constraints be placed on how the individual provides the information and that data should not be interpreted while it is being collected. Phenomenological research is a qualitative research method which provides insight into the meaning of everyday living. It provides understanding of being human in a complex world (Adams & Van Manen, 2017).

Because the intent was to explore the unique experiences of a specific and unique construct with cultural elements, phenomenological study allowed me to focus on this connotation. This particular study allowed me to highlight meanings, particularly how elderly Latino women cope with depression utilizing concepts of familismo in everyday living. Phenomenological research allowed me to assess the unique way concepts of familismo are implemented to manage and regulate symptoms of depression.

Role of the Researcher

In this qualitative study, my role was that of a facilitator and evaluator. As the organizer, I observed how participants portrayed and expressed their experiences. It was vital that I discard any biases I may have regarding the topic. As suggested by Flood (2010), prior to beginning the investigation, I had to abandon my own attitudes, feelings, and knowledge of the phenomenon. As a behavior health psychotherapist, I do have prior knowledge about depression and have had the opportunity to work with elderly Latino

women. I have not had personal experience with depression but do recognize that I am a member of the national heritage and ethnic group being researched.

To ensure that I maintained objectivity throughout the research, I bracketed all personal biases. To interpret the participants' experiences with depression, mental health, and familismo, I selected participants with whom I had no personal or professional association. In order to limit the issues of biases that may arise due to placing myself as the researcher, I followed Flood's (2010) recommendations, which are based on Husserlean philosophy and included shedding all former personal knowledge (bracketing) to prevent prejudices or presumptions that may influence the study and utilized only essential components by removing inconsequential data. The idea of bracketing notes that researchers will remain objective and impartial by detaching self from any pre-existing knowledge or assumptions regarding the phenomena to focus solely on the participants lived experience (Wilson, 2015).

Researchers play an influential part in the investigation (Karagiozis, 2018). Karagiozis (2018) suggested that the researcher is the key instrument within both data collection and analysis; therefore, researchers should possess strong interpersonal skills. Karagoiozis described a skilled qualitative researcher as one who is (a) aware and sensitive to ethical concerns, (b) able to develop a trustful connection with participants, (c) respectful of participants' individuality, (d) and understanding of participants' perspective. Because the dynamic between the researcher and the participant is vital in qualitative research, Karagoiozis suggested that the relationship should be professional and that researcher should reveal little to nothing about themselves and focus on having

participants reveal information about themselves. Ultimately as the researcher, I had authority of how the specific approach was implemented, how data was collected and interpreted, and production of the research findings (Karagiozis, 2018).

Methodology

With the phenomenological approach of this study, an appropriate data collection method were interviews. Interviews allows researchers to gain knowledge and understanding of the phenomena by focusing on views of the participants. Interviews are flexible and allow for in-depth analysis from a modest sample size (Benitez et al., 2018). Specifically, I conducted individual, one-on-one semistructured interviews. I chose this interviewing method over other qualitative data collection methods because interviews allowed me to gain insight into the experiences and perspectives of individual participants. In addition, one-on-one semistructured interviews are generally organized around a set of predetermined open□ended questions, with other questions emerging from the dialogue between interviewer and participant (DiCicco-Bloom & Crabtree, 2006).

Individual interviews gave me the opportunity to schedule a convenient time and location for the participant. Ungvarsky (2018) indicated that, in phenomenological research, individuals can share information orally, and interviews allows researcher to take notes on nonverbal responses and reactions observed as they discuss experiences. For this research, I took field notes during the interviews. By doing so, I was able to document contextual information which was later disseminated for secondary analysis (Phillippi & Lauderdale, 2017). Field notes included personal queries and thoughts

regarding the interview and my observations during the interview (Phillippi & Lauderdale, 2017).

Research Questions

Adams and Van Manen (2017) indicated that a phenomenological question should aim to provide meaning to a recognizable experience. Phenomenology focuses on *lived experience*, "that is, as it is, was, or may have been experienced in the lived moment" (Adam & Van Manen, 2017, p. 782). Phenomenological questions use the term *experience*, specifically, and can be composed as: *What is the lived experience of …* (Adam & Van Manen, 2017). Phenomenological research questions center the interest on the "lived meaning of the experiential moment itself" and avoids opinions, justifications or other post-interpretations regarding the experience (Adams & Van Manen, 2017; p. 782).

Because the goal of this study was to explore the elderly Latina's experience of how cultural concepts of familismo are utilized to cope with major depressive disorder, the fundamental question that guided the research was: What are the lived experiences of depression among elderly Latino women between the ages of 50 and 75 and how do they skillfully implement cultural concepts of familismo to cope with symptoms of major depressive disorder? The goal of investigating this question was to identify patterns or themes that could provide mental health practitioners a better understanding of how the use of these specific coping skills can help treat major depressive disorder and how to implement skills in the treatment plan.

Interview Questions

DiCicco-Bloom and Crabtree (2006) suggested that a basic research question can be the first interview question followed by five to 10 specific questions that focus more on different aspects of the study. Example of questions asked for this study included:

1. How long have you been diagnosed with depression?
2. What are your beliefs about depression?
3. Have you discussed your major depressive disorder diagnosis with your family?
4. Do you feel that disclosing your diagnosis with your family has helped you cope with the diagnosis?
5. How do you utilize your family to cope with major depressive disorder?

Participant Selection

The population for this study were Latino women between the ages of 50 and 75 who have been clinically diagnosed with major depressive disorder by a mental health professional and who reside in Houston, Texas, specifically Harris County. Participants had to be currently in mental health treatment or have been active in treatment within the past year (12 months) in order to participate in this study. For this study, comorbid diagnoses were excluded. All participants reported no cognitive disabilities and legally consented to be able to and willing to actively participate. A vital characteristic was that individuals have a positive support system with their family as concept of familismo was being explored.

Sampling Strategy

In order to ensure that participants were able to contribute to the study, it was critical that individuals met the required criteria. Purposeful sampling helped select the most appropriate information-rich individuals that were competent and informed about the phenomenon and able to provide knowledge via their experiences (Etikan, Musa, & Alkassim, 2016). In addition, purposeful sampling specifically allowed elderly Latino women between the ages of 50 and 75 to communicate and express their experiences and opinions on how cultural concepts of familismo are used to cope with depression (Etikan et al., 2016). Homogeneous sampling was used as I focused on specific characteristics and participants who shared comparable and related traits (Etikan et al., 2016). Participants were similar in age, culture, and all had experience with major depressive disorder and presented with a family support system.

Having the largest medical center in the world, Houston, Texas, is considered one of the best medical communities (City of Houston, n.d.). With several potential cites I focused on agencies that primarily provide minority care, specifically Latino population. The City of Houston website (n.d.) reported that multi-service center such as community health centers are strategically located across the city. I reached out to the identified locations and introduced my-self and the study. Then, I assessed whether the location was suitable and appropriate for the study and ask management if an official and approved flyer could be placed around the facility, where participants can be reached. Flyers had researchers contact information. The posted flyer had the criteria participants needed to meet. Upon being contacted by a potential participant, I further assessed eligibility by

asking pre-interview questions. Participants who meet all inclusion measures were invited to participate in the interview process.

Fusch and Ness (2015) explained that research designs are "not universal" and there is "no one size fit's all method" to attain saturation (p.1409). *Data saturation* occurs when the researcher has collected adequate information and has reached a point where no new data and no further coding or themes arise (Fusch & Ness, 2015). Guest et al. (2006) recommended that, during the interview, all participants be asked the same questions. In this phenomenological study, using questions that were probing constructed a state of *epoché* which helped reach data saturation. As recommended by Fusch and Ness (2015), the primary focus was on gathering rich and thick data when interviews were facilitated. There are limited sources that provide actual sample size guidelines. Corby, Taggart & Cousins (2015) inform that in a phenomenological study, the number of participants range from 4-15 with 8 being the average in order to reflect diversity within a small sample, while Guest et al., (2006) suggested that 15 participants are the smallest samples size acceptable for this chosen study. For this study, I had a sample size of 8 participants in order to simultaneously comply with the sample size suggested by Creswell (2013) and Guest et al., (2006). Registration ended once data saturation had been met.

Instrumentation

In order for the instrument to be considered credible, results should be similar when replicated using the same methodology (Golafshani, 2003). For this study, I used interviews as the primary means of gathering information. Interviews are the primary method of data collection in a phenomenological study (Flood, 2010). Interviews allowed

me to explore, illuminate, and probe participant's description of the phenomena and reflect on the data provided (Flood, 2010). McIntosh and Morse (2015) advised that interviews and questions asked should have four purpose; they should be "descriptive/confirmative, descriptive/corrective, descriptive/interpretative, and descriptive/divergent" (p.1). To gather data, I used three instruments which are discussed in the data collection section of this chapter.

Data Collection

For this phenomenological study, interviews were the main data collection method in exploring the lived experiences of elderly Latino women as it relates to how they utilize familismo as a coping skill to manage major depressive disorder. Given that exploring the lived experiences is the primary intention of the study, semi-structured interviews were held and transcribed. In a phenomenological interview, the researcher is studying a participant who provides accounts of their world, themselves, and their perception regarding experiences in order to bring about knowledge (Hoffding & Martiny, 2016). In depth interviews allowed for firsthand and direct knowledge about the individual being interviewed which will provided a large amount of discursive data (Hoffding & Martiny, 2016).

Simultaneously, interviews provided tacit knowledge which was found in the participants body language, tone usage and facial expressions, which otherwise could not have been obtained. Because the study was constructed on interpretive phenomenology, the best approach on gathering data was interviews.

In addition to conducting interviews, I kept field notes. Field notes allowed annotations of impressions, nonverbal cues, behaviors and environmental context not otherwise captured via audio-tapes (Sutton & Austin, 2015). Field notes helped interpret context of the interview which was vital during data analysis. (Sutton & Austin, 2015). A reflexivity journal was also kept throughout research. Reflexivity journaling is further discussed when I address trustworthiness in this chapter.

In order to recruit participants for this study, I started by obtaining permission from local senior centers whose population are those over the age of 50, as mentioned previously. Facility managers signed agreement forms. Once approved, flyers were placed in common areas. The flyers included inclusion and exclusion characteristics along with researchers contact information.

Once participants were selected, I contacted participants to arrange face to face, one-on-one, in person interviews. Participants were informed that participation was voluntary. To ensure no coercion, participants made the first contact by calling the number on the flyer. I allotted 90 minutes for each interview. During this time, the researcher gathered information regarding demographics (see Appendix A), had each participant sign consent forms, were asked permission for the interview to be audiotaped and were advised that notes will be taken throughout the interview.

Informed consents allowed for participants to be engaged in the decision-making process (Spatz, Krumholz, Moulton, 2016). Informed consent were obtained by each participant. Informed consent included (a) pertinent information regarding the benefits and risks of the study, (b) duration and process of the research, (c) right to decline or

withdraw from the study, (d) patient's rights, and (e) limits of confidentiality (Spatz, Krumholz, & Moulton, 2016). Each participant signed a consent form agreeing to participate in the study. Prior to beginning interview questions (see Appendix B); participants were given the opportunity to ask any question they may have had. Each interview was recorded utilizing a digital audio-tape with a recorder which allowed for the interview to be transcribed at a later time.

Interview Process

Upon screening the participants to ensure they met inclusion criteria; I began to arrange interviews. Each participant was contacted via phone to schedule a date, time, and location for their interview. Participants were allowed to choose the date and time for the interview. Concerning the location, all participants agreed to met me at my private practice office. A study conducted by Jenner and Myers (2019), concluded that participants are more apt to disclose negative emotions, share judgmental attitudes and information which can be stigmatizing when interviews were performed in-person and privately. I provided a safe and comfortable site for the participants.

Data Analysis

Being true to the participant is the most critical part of data analysis in a qualitative study (Sutton & Austin, 2015). I used the data analysis approach of Sutton & Austin (2015). Sutton and Austin (2015) instructs that researchers should

1. transcribe and check,
2. read between the lines,
3. code,

4. theme, and
5. synthesize data.

Transcribing was completed so that spoken words are converted to written words that can be analyzed (Sutton & Austin, 2015). Coding allowed me to identify similarities regarding topics and issues revealed via the narratives (see Ravitch & Carl, 2016). After coding, themes were identified. Coding for themes implied that I assembled codes from all transcripts and comprehensibly emerging meaning from the findings that would ultimately synthesize data (Sutton & Austin, 2015).

Issues of Trustworthiness

For research findings to be pertinent or make significant difference in practice, it is critical that the research is trustworthy and transparent. In a quantitative research, rigor can be confirmed by applying validity and reliability whereas in a qualitative study, to describe rigor, researchers must integrate methodological strategies of trustworthiness of the results (Noble & Smith, 2015). Trustworthiness is a qualitative research technique which adopts terminologies such as dependability, credibility, conformability, and transferability (Hadi & Closs, 2016).

Dependability

The constancy of the data over time and over the conditions of the research refers to *dependability* (Polit & Beck, 2014). Similar to reliability in a quantitative study, dependability describes the stability of conditions throughout the study (Connelly, 2016). To ensure dependability, all data collected and analyzed was supported by the data collected via interviews which came directly from the participant.

Credibility

The most critical criterion regarding trustworthiness is *credibility,* which refers to the confidence in the truth of the study and its findings (Connelly, 2016). Connelly (2016) reported that credibility is equivalent to internal validity in quantitative research. Prolonged engagement with participants, persistent observation and reflective journaling are several techniques that a researcher can utilize to establish credibility. Data should be examined several times and in case of negative analysis, Connelly (2016) recommended that alternative explanation should be explored. Mandal (2018) informs that for a study to be credible, research participants must accurately be able to provide enlightenment upon the phenomenon. Researchers are required to make rigorous analysis which can be replicated and examined by external parties; therefore; data must be logical and justified (Mandal, 2018). To ensure that the data gathered for this research is credible, I reviewed the data several times. I transcribed the audio recordings, read the data collected several times, created initial codes and review/ revise and combine themes to better analyze the data.

Conformability

Connelly (2016) wrote that *conformability* refers to the objectivity of the findings and the degree or consistency in which the findings could be repeated. Several steps were taken to ensure that biases are excluded from the findings and results of the study were the ideas of those participating rather than belief or opinions of the researcher (Pandey & Patnaik, 2014). I took unobtrusive measures to ensure that data was authentic and clear.

Transferability

Transferability indicates the degree in which data and conclusions are applicable or useful to broader concepts such as individuals or other settings (Connelly, 2016). Ravitch and Carl (2016) called attention to the importance of remaining true to the data while considering how the study can be applied to wider notions. Similar to generalization in quantitative research, Connelly (2016) instructs that researchers must apply procedures that fit research design being employed.

Strategies to Ensure Trustworthiness

To ensure trustworthiness in the qualitative findings, I utilized two strategies, reflexivity and triangulation. Triangulation is the use of various sources to data collection in attempt to draw a comprehensive conclusion and perception of the phenomena (Cope, 2014). Data collection methods includes the interviews, field notes and observations. Reflexivity is the researcher's awareness that their background, previous experience, values and biases regarding the phenomena can affect the research process (Cope 2014). To ensure that I remained objective I kept a reflexivity journal. This reflective journal helped identify personal biases, personal beliefs and any other external personal factors that may have influence the research findings (Hadi & Closs, 2016). I also used field notes to reduce biases (Hadi & Closs, 2016). According to Hadi and Closs (2016), to certify credibility and conformability, triangulation can assert validity as it involves utilizing two related sources of data or methods of collection to reduce inherent bias (Hadi & Closs, 2016). Triangulation and reflexivity are additional strategies that were used to enhance trustworthiness and credibility of the study.

Ethical Considerations and Protection Measures

To ensure compliance with ethical and legal codes, I applied to the Walden University's Institutional Review Board (IRB) for approval to execute this qualitative study (approval number 11-06-19-0642197). I did not attempt to contact individuals, agencies, or organizations prior to approval. No conflict of interest existed for this study. Individuals suitable for this study were be Latino women between those ages of 50 and 75, clinically diagnosed with major depressive disorder and willingly volunteered to engage in the research.

This research did involve sensitive topics such as mental health and family dynamics. Stress and potential emotional discomfort could have occurred in this study; there is no known harm linked with this research. No participant expressed extreme discomfort, there was no potential harm to self or others or inducing/escalating depressive symptoms. Each individual was provided with a referral list of community mental health services at the end of the interview.

Confidentiality

Provisions were made to ensure confidentiality. Prior to gathering information, as mentioned, I first obtain permission from the IRB. Once permission was granted, research process began. Each participant was required to sign consent form, which include a privacy clause. To further ensure confidentiality, identifiable information was concealed. Personal identifiers, locations and organizations were not used. Each participant was assigned an identification number to maintain adequate information. Only consent forms contain real names, demographic and contact information. Consent forms

are stored securely in a locked file cabinet in my personal private practice office. Only I have access to office and locked box keys.

Consent Forms

I met all requirements stipulated by Walden University's research ethics board. Throughout the research process, I remained respectful, sensitive and tact towards each participant. As suggested by Seidman (2006) and DiCicco-Bloom and Crabtree (2006), an invitation to participate was provided to all individuals who meet requirements for participation. This invitation included what the research was about, how long the interview was projected to take, all possible risks, their rights as a participant, benefits, confidentiality, how data will be collected, dissemination of data and contact information. All participants were required to sign consent form prior to interviews.

Compensation

In a research study, Lamkin and Elliott (2018) suggested that participants be compensated for their time and benefits should be shared as they bear the risk of the research. Although in this study the participants did not incur charges such as parking; their time was compensated. I provided all participants who completed the research interviews a $20 Visa gift card. Payments were kept low to prevent participants from risking their health and decrease undue influence (see Lamkin & Elliott, 2018). During the consent stage, I reviewed compensation and participants were informed that they were receiving gift card upon completion of their interview. Lamkin and Elliott (2018) suggested that compensation should be ethically sound and fair for participants to make a

sound and voluntary decision on whether to participate. Gift cards were personally funded and supplied by me.

Summary

In this chapter, I outlined how the study was conducted. This chapter included a synopsis of how I implemented a phenomenological design and research methods used to explore the lived experiences of Latino women, 50-75, who have been diagnosed with depression, and how they use familismo to cope with daily living. This chapter included the methodology, setting of the research, participant selection along with procedures I utilized to address the research question. This chapter included discussions of the ethical guidelines that were implemented to ensure safety of each participant as well as measures taken to protect confidentiality. I also explained all data collection instruments that were used, along with issues of trustworthiness.

Chapter 4: Data Collection, Analysis, and Results

Introduction

The purpose of this phenomenological study was to explore how elderly, Latino women residing Houston, Texas, between the ages of 50 and 75, utilize concepts of familismo to cope with major depressive disorder. I applied components and methods set forth by Van Manen and Adams (2017) to complete this phenomenological study. Adams and Van Manen (2017, p. 780) suggested that a phenomenological study "is an experience-based and text-oriented approach." The design utilized for this study included open-ended research questions that "points to a recognizable experience" (Adams & VanManen, 2017, p.780). Through conversations held amidst the interviews, participants had the opportunity to freely interconnect their thoughts and personal experiences of how they utilize familismo as an instrument to cope with major depressive disorder. This chapter of the study comprises the description of the qualitative data collected throughout the eight interviews conducted. This chapter includes an overview of the data collection and procedures, participant profile and analysis of the data.

Setting

Collection of data began once the IRB approval was received from Walden University. Once approved, I began the recruiting process by posting flyers in four identified locations in Houston, Texas that were approved by the IRB. Organizations did not recruit nor pre-screened for participants. Two of the approved organizations are private psychotherapy practices. These practices allowed me to place flyers in their reception/waiting area. As an essential part of credibility of the study, organizations were

asked not to answer questions about the study nor otherwise encourage participation. A contact number was provided on the flyer. Participants made the initial contact for further information. If interest and inclusion criteria was met, an interview appointment was scheduled within that week. I interviewed eight women; two women obtained the flyer from participants previously interviewed.

To proactively manage any potential conflicts of interest, flyers were not posted at organizations where I was previously or currently employed. Furthermore, I do not provide services to participants included in this study. My previous and current clients were excluded from participating in this study. The sole role of the partner organizations was to allow me to post flyers.

Interviews for this study were conducted between November 2019 and January 2020. All participants elected to have the interviews conducted at my private practice office. No names were used throughout the interview, and participants were identified by number only (i.e., P1-P8). All interviews were held with the participant only. Family members and significant others who accompanied the participant were kindly asked to wait in the office lobby. All interviews were conducted face to face and in the participants' preferred language. P1 and P5 were the only participants who spoke two languages: English and Spanish. P1 chose to have her interview conducted in English; P5 opted for Spanish. All other participants only spoke Spanish. Conducting the interview in English with P1 did not appear to affect the interview. Table 1 shows the participants' country of origin and language spoken. All participants originated from Spanish-speaking countries and are either first- or second-generation Latinos.

Table 1

Participant Country of Origin and Languages Spoken

Participant	County of origin	Language spoken
P1	Mexico	Spanish/English
P2	Cuba	Spanish
P3	Cuba	Spanish
P4	Mexico	Spanish
P5	Puerto Rico	Spanish/English
P6	Mexico	Spanish
P7	Mexico	Spanish
P8	El Salvador	Spanish

On the day of their scheduled interviews, I reviewed consent forms, the confidentiality agreement, and demographic document with each participant. Upon completion of the documentation review, the participants had no questions, and each participant signed all the necessary forms. Each participant was provided with a copy of the consent forms once I signed them. To ensure privacy, identifiable personal information were replaced with ID codes. Forms were identified with a P (for participant) followed by a number (i.e., P1-P8). No names were incorporated in the ID codes. A master code list was created, and I am the only person with access to this list. The list is stored separately in a locked cabinet in a locked office. Contact list, consent forms, recruitment records, and other documents that may contain personal information will be destroyed after 5 years. Audio tapes are stored securely in a locked cabinet when not in use. Only I handled the audiotapes. Electronic data are stored in a password-protected computer file. Data records kept in my laptop are secured by using a double password.

Passwords are difficult to determine in order to further protect data. The computer used for data analysis was configured to "lock out" after 20 minutes of inactivity. Participants were reminded that participation for this study is voluntary and all individuals elected to complete the interviews. There were no issues presented by participants or organizations that might have influenced interpretation of the study results.

During the semistructured interviews, coffee, water, and snacks were offered. The interview was guided by preapproved questions, with probing questions and clarification questions asked as needed. I took notes throughout the interviews and recorded all interviews using an audio recorder. Interviews lasted between 60-90 minutes. Participants elaboration of their lived experiences influenced the duration of the interview. A $20 Visa gift card was provided to participants at the end of the interview as reimbursement for their time.

Demographics

Table 2 provides an overview of the demographic profiles of the eight participants in the study. Age range for participants were between 52-75 ($M = 65$). As noted in the inclusion criteria, all participants were female and Latino. All participants are diagnosed with major depressive disorder by a mental health professional. Almost all participant are currently in mental health treatment with a mental health professional. Five out of eight participants are married. Two out of eight participants are currently employed full-time. One participant reported that she is retired but continues to work part-time due to finances. Two participants were diagnosed in their 20s, one participant was diagnosed in

their 30's, two were diagnosed in their 40s, two participants were diagnosed in their 50s, and one participant was diagnosed in their 70s (Average age $M = 42$).

Table 2

Participation Demographic

Participant	Age	Marital status	Education level	Age when diagnosed	Treatment	Employment
P1	75	Married	Bachelor's degree	73	In treatment	Retired
P2	59	Married	Some college	"20-something"	In treatment	Unemployed
P3	68	Married	Training school	"44 or 45"	In treatment	Unemployed
P4	64	Widow	High school	22	In treatment	Retired
P5	64	Married	Some college	50	In treatment	Retired/PT
P6	52	Single	High school	50	In treatment	Full-time
P7	75	Married	No education	"40s"	Not in treatment	No work history
P8	57	Separated	High school	"30s"	In treatment	Full-time

Note. $n = 8$. In treatment = established with a mental health professional.

Data Collection

The primary source of data collection were interviews. All interviews were held face to face. All interviews were facilitated at my private practice office. All 8 interviews were recorded using a digital audio recorder. Average range for each interview was 60-90 minutes. Consent forms, demographic questionnaire and interviews were given in the participants preferred language. Seven interviews were conducted in Spanish; 1 interview was conducted in English. I am fluent in both Spanish and English therefore interpreter was not needed. All interviews were conducted over a 3-month period.

Upon completion of the interview, each participant was provided with a list of mental health resources and agencies in the Houston area. To confirm accuracy of the transcript, participants agreed to a 30-minute follow-up meeting via phone.

Additional data source includes notes taken during the interview**,** such as observations, reflecting thoughts or memos taken by me. Field notes were included in the coding process and transcript. I collected data through individual (n = 8) interviews that were semi-structured. Interviews were audio recorded and guided by open-ended pre-approved interview questions. The same interview questionnaire tool was used in all interviews (see Appendix B). During each interview, field and reflective notes were taken to note any non-verbal communication, reactions and observed changes.

Upon completion of each interview, I began transcribing data. The transcription lengths varied with time ranging from 10 hours to 26 hours. This accounts for accuracy of translation, such as to ensure direct proverbs or idioms from their culture are kept exact and precise. By the sixth interview, saturation was reached. Codes and categories had begun to arise. Interviews with participant seven and eight had already been scheduled; therefore, I completed interviews to ensure full data saturation. Data saturation was reached with eight participants as no new significant themes emerging.

Data Analysis

Data analysis was based on Sutton and Austin (2015) interpretive analysis model which instructs: transcribe and check, read between the lines, code, theme and synthesize data. I personally transcribed all interviews verbatim using Microsoft Word 2016. Personally**,** transcribing data allowed me to immerse myself in the data. Reading

and re-reading further allowed immersion. As suggested by the committee chair, I transcribed and translated themes stated in participants' language (Spanish) into the primary language of the researcher, committee chair and methodologist during data analysis (English).

Upon completion of transcribing interviews, I summarized, organized, and described participant's data using key concepts of coping skill theory models. I began to organize findings with descriptions**,** including themes or categories. Each line was read for coding consideration. To ensure that I do not assume pre-established biases, I maintain alignment with my particular paradigm and remain consistent with my methodology reflexivity journaling (Blair, 2015). It was noted that participants at times discussed unrelated matters irrelevant to the study. I briefly allowed the dialogue as Van Manen, 1990) suggested that it supports and maintains rapport. When this occurred, I would gently direct them back to the study by asking relevant questions. For analysis purposes, I marked these exchanges within the transcript in parenthesis.

Succeeding the transcription stage, as advised by Sutton & Austin (2015), I began to read between the lines. I used Microsoft Word 2016 to assist in coding. To help organize and structure the coding process, I used research questions as guidance.

Codes and Themes

Codes were organized in clusters of related replies. The response of 8 participants were regarded to show interview responses. The first review of the transcripts, I solely read the narratives and made general descriptions and notes on the side and highlighted key concepts. This initial review also included field notes. Table 3 represents descriptive

codes, which summarizes the primary topic of transcripts and number of participants with similar responses. Table 3 captures language based on the data gathered from the transcripts. Table 3 is the second cycle in the coding process in which I synthesized the information using one word responses or sentences. In table 3, I extrapolated the most important ideas relevant to each research question. These codes were taken from what participants themselves said. The second time going through the transcripts, I attempted to condense the data. This phase in coding derived from the 16 open-ended questions asked during the interview.

Table 3

Interview Questions, Codes, and Number of Replies

Interview question	Codes	Number of responses
1	Age of Diagnosis	
	20s	2
	30s	1
	40s	2
	50s	2
	70s	1
2	Was family informed when initially diagnosed MDD	
	Yes, I made my family aware when initially diagnosed	3
	No, I did not make my family aware when initially diagnosed	5
3	Reasons for seeking help or not seeking help	
	I was overwhelmed	1
	I was confused	2
	I was in disbelief	2
	I was ashamed	3
4	Personal Perception regarding MDD diagnosis	
	I did not realized I was suffering from depression	2
	I do not believe I have depression	2
	Everyone gets sad	4
5	Disclosing MDD diagnosis to family	
	Yes, I discussed MDD with my family	7
	No, I have not discussed MDD with my family	1
6	How family influence depression positively	
	Yes, they are very supportive	4
	No, I have not told them	1
	Unsure, they are empathetic and try	3
7	Use of familismo to cope with diagnosis	
	I talk to them everyday	3
	When feeling discouraged I seek them	1
	I do not, I do not want to bother them	3
	I go out when they invite me	1
8	Impact familismo	
	Yes, I feel like they are too overprotective	3
	Yes, we are a lot closer	2
	No, they are still kind and supportive as usual	3

(table continues)

Interview question	Codes	Number of responses
9	Impact of manifestation on relationship with family	
	They became extremely worried	2
	They did not want to leave me alone	3
	They had a lot of questions I could not answer	2
	We cried	1
	They were helpful	1
10	Influence familismo has on outcome	
	They are helpful and supportive	3
	They check in on me	1
	They don't really have a role	2
	They take me to appointments	1
	I could not do this without them	1
11	Hesitations for not disclosing	
	I knew they were going to worry	6
	I was still trying to cope myself	2
12	Importance of self-disclosure to family	
	It is important that my family know I'm in treatment because I wanted them to know I was getting help	6
	Indifferent whether I disclosed to family	1
	Moderately important that I disclosed to family	1
13	How familismo influence treatment	
	Yes, my family influences my treatment	3
	Yes, they help me want to work through it	3
	Yes, they are the reason I'm getting help	1
	No, my family knows I'm in treatment, but they are not engaged in my treatment	1
14	Personal perception of self since MDD	
	I notice changes in my behavior and emotions	3
	I think I still have some ways to go	1
	I am a lot stronger and have overcome it	2
	I still feel confused and overwhelmed	2
15	Reasons for not seeking help	
	I thought I could deal with it myself	2
	I didn't know what was going on and thought it was going to go away	2
	I was feeling good for a while so thought it was normal	1
	I did not want to be labeled as crazy	3
16	Change in perception of MDD since use of familismo to cope	
	Yes, I will overcome this, depression is not a bad thing	4
	Yes, I realized that it's ok to feel this way	3
	No, I still don't want people to know; still not ok for me to say I have MDD	1

Emerging Themes

Themes were developed by organizing and clustering similar responses. Table 4 displays the third review of transcripts in which I grouped related codes to begin filtering and developing themes. The third time coding the transcript, I began to categorize codes. Per Grbich (2007), this process allows data to be grouped and regrouped to help merge meaning and exploration. In this phase, I organized similar coded data into categories of common characteristics. To ensure that I was capturing codes, I reviewed data, codes and themes a forth time which also included field notes and reflexive journals entries. This helped reflect on emerging themes and ensure I am giving meaning to the experiences told by the participants. Themes were developed from the descriptive codes displayed in Table 3 (see Table 4).

Table 4

Emerging Themes

Themes	Related codes
Influence and role family support has on coping with depression	Yes, they are very supportive No, I have not told them Unsure, they are empathetic and try I talk to them every day, I feel ok talking about it When feeling discouraged I seek them I do not, I do not want to bother them I go out when they invite me They are helpful and supportive They check in on me They don't really have a role They take me to appointments I could not do this without them It is important that my family know I'm in treatment because I wanted them to know I was getting help Indifferent whether I disclosed to family Moderately important that I disclosed to family
Impact of behavioral and emotional changes since deciding to disclose diagnosis to family	Yes, I feel like they are too overprotective Yes, we are a lot closer No, they are still kind and supportive as usual I knew they were going to worry I was still trying to cope myself I notice changes in my behavior and emotions I think I still have some ways to go I am a lot stronger and have overcome it I still feel confused and overwhelmed Yes, I will overcome this, depression is not a bad thing Yes, I realized that it's ok to feel this way No, I still don't want people to know; still not ok for me to say I have MDD
Acknowledging depression	I was overwhelmed I was confused I was in disbelief I was ashamed I did not realize I was suffering from depression I do not believe I have depression Everyone gets sad They became extremely worried They did not want to leave me alone They had a lot of questions I could not answer We cried They were helpful I thought I could deal with it myself I didn't know what was going on and thought it was going to go away I was feeling good for a while so thought it was normal I did not want to be labeled as crazy
Family Inclusion	Yes, I made my family aware when initially diagnosed No, I did not make my family aware when initially diagnosed Yes, I discussed MDD with my family No, I have not discussed MDD with my family Yes my family influences my treatment Yes, they help me want to work through it Yes, they are the reason I'm getting help No, my family knows I'm in treatment, but they are not engaged in my treatment

From the data analysis displayed in Table 3 and 4, three primary themes were identified. Themes identified included:

1. Acknowledging major depressive disorder
2. Impact of behavioral and emotional changes since deciding to disclose diagnosis to family
3. Influence and role family support has on coping with depression
4. Impact of family inclusion when initially diagnosed with major depressive disorder

Theme 1. Acknowledging major depressive disorder. During the interview, participants were asked a series of questions in which they described their perception about major depressive disorder and emotions associated with the diagnosis. This included their feelings when suffering from depression both before and after the diagnosis was disclosed to the family. Participants' response provided insight on symptoms they experienced when initially diagnosed, their acknowledgement of diagnosis, how they normalized their emotions and how their response revolutionized once they include support from the family.

Acknowledging depression can be challenging due to individuals normalizing symptoms as they have lived with them so long. Participants explained phenomena and their reaction. Their experience and understanding are delineated as follows.

Participant #1 stated,

Back then nobody talked about depression, honestly, I don't think we knew what that was. My mom would just tell me to stop being sad and stop trying to get

> attention because I was always crying. I think she thought I was jealous of my sisters or something**,** but I was just sad all the time. I'm not even sure why I cried. I wasn't unhappy, I was just not happy. I think I didn't like my mom because she said that to me. I remember one day I did not want to go to the fields with them and she got so mad she kept hitting me. It was my dad who said it was not normal and he took me to get checked.

Participant #2 stated,

> I always felt like something was missing. I felt like I was just there, I did not really feel anything. You know, in Cuba many people are just living so for me this was normal. I remember talking to my mom and she told me, "mija" I know exactly how you feel. She just told me that but never told me it was depression. So now when I look back, my mom also had depression. I think we all just suffer over there and nobody says anything.

Participant #3 stated,

> I did not know I had depression. You know I'm getting old and things are hurting, and I miss my family but that is normal. My husband gets mad at me sometimes because he thinks I cry a lot. {Name of doctor, participant stated full name} told me to come see someone and the lady told me I had depression. I think it was the social worker, but I told her I did not and I was just sad and she told me that it is not the same and everything she was telling me that is what I was feeling. Except kill myself, I will never do that.

Participant #4 stated,

> You know when I came to this country, I was so sad. I miss my home. I could not sleep, and I told my daughter I want to go back, and she said no. We argued because I wanted to go back, I don't like it a lot here. And then she brought me to the doctor because she thinks I need help, but she needs help.

Participant #5 stated,

> I know I had depression. I came to the doctor to get medicine because I cry and cry after {participant states husband name} died. I'm just sad all the time. Sometimes I cannot handle it and I just want to be alone. My children keep coming and I keep telling them I'm ok. I have medicine to help me sleep too. I think I have medicine for the sadness too.

Participant #6 stated,

> I was diagnosed with depression when I was 50. I don't have husband or children and I'm just alone. My mom died two years ago and I'm all alone, but I got to talk to someone, a therapist or social worker, I think. I have a lady who comes and helps me clean and I talk to her too.

Participant #7 stated,

> Yes, depression is really bad, but I think I'm feeling better. My son was drinking and drinking, and I could not sleep because I was always up. Seeing him like that made me so sad. I had him living with me for a while, but he just kept making me sad. He did not want to stop, but now he stopped and I'm not worried so much. I couldn't sleep or eat or nothing until I got a call from him.

Participant #8 stated,

> Twenty years ago I started taking medicine. We have a "culandera" that I was getting tea from because my husband told me that he thought I was depressed or something. I take the tea and then when I got here, I told the doctor everything. I don't know America yet, but it is so different. Makes me miss my country but I'm ok here. I take medicine to help me and I'm not so sad so much. I sleep more.

Depression presents with persistent feelings of sadness, which can affect everyday functioning. Although complex in how it may be experienced individually, acknowledging need for treatment is a form of how these individuals helped themselves. Participants provided insight on their experiences on the importance of confiding in others and seeking out mental health treatment to improve daily living.

Theme 2. Impact of behavioral and emotional changes since deciding to disclose diagnosis to family. *Familismo* "is a cultural value frequently seen in Hispanic cultures, in which a higher emphasis is placed on the family unit in terms of respect, support, obligation, and reference" (Valdivieso-Mora, Peet, Garnier, Salazar & Johnson, 2016, p. 1632). Participants were asked to describe, specifically, how they utilize family to cope with depression. They were asked questions regarding family involvement and the impact it had in the outcome of their mood. All participants recalled how they utilized family support to manage symptoms of depression.

Participant #1 stated,

> You know what, I think my husband is depressed. It makes me depressed that he is depressed so I talk to him a lot. I told him to get help too but he is so stubborn.

> My daughters did not believe I have depression because I am a happy person**,** but I told them how hard it is. They are so nice to me. They bring us dinner and talk to me. I don't know why they changed so much. They are just so nice now. They used to be grumpy and mean to me but I think that I'm getting older and they are getting nicer.

Participant # 2 stated,

> Here is a lot different. Everyone is closed and stays home and does not talk. That is why we are sad, we are just alone, we don't talk. Back home no one closed their doors, we all knew each other, there is depression**,** but it helps to talk to everyone. I have to be around people. I talk to my mom on the phone every day, I talk to my daughter, I go to church. I have to do things to keep me happy. Only my family knows the doctor told me I have depression and I don't tell people**,** but it helps just being around the people you love.

Participant #3 stated,

> My husband was with me at the doctors when my doctor to me to talk to someone because she says I have depression. He told her I was always crying. I have Parkinson's and I don't like when I shake. He tells me who cares what people think but I don't want to bother my family. I only talk to my husband who is really supportive; I was trying to do it myself. My husband and kids are so nice and they really take care of me. My son dropped me off here because I cannot drive anymore.

Participant #4 stated,

> I am ok. I don't think I have depression. My daughter just wants to take care of me. I am tired, not depressed and I keep telling my daughter that. She thinks because I like to stay home I'm depressed. She takes me out**,** but I want to be home. We live together with my grandson so we talk a lot. I do tell her when I'm sad.

Participant #5 stated,

> I have a good family. When {participant states husbands name} died they stayed with me and bring me food. You know that they really showed me they cared. I didn't want to take showers and they were there. They tried to talk to me a lot and they call me**,** but they have always been like that.

Participant # 6 stated,

> I cry and cry a lot and my doctor told me that it's ok to cry but she told me that I need to talk to people and not always stay home. The doctor signed papers for a lady to come help me cook, I talk to her. She is really nice; she is a Mexican lady too.

Participant #7stated,

> Oh no no, I don't want my family to worry. They think I just go to the doctor**,** but I see a therapist. I don't want them to worry. I go to church and I pray but I think I am better now. When my husband died my children stayed with me for a little bit**,** but I told them to leave because I do not mind being alone. Every Sunday they come to eat at my house but no, I do not talk to them about nothing because they

> will just worry. I feel happy knowing that they are happy. I don't want to worry them.

Participant #8 stated,

> Oh yes**,** I told my family I have depression. I told them because I needed help. I know I have something**,** and I know I have a lot of things I'm feeling but I have my family. I believe that the spirits and God are helping me**,** and my family and friends are helping me here on earth.

There are numerous factors, which can affect an individual diagnosed with major depressive disorder. Participants all focus was on love ones well being and there perception of protecting influenced their decision to include them in their treatment or care. Family and emotions support are invaluable to a depressed person.

Theme 3. Influence and role family support has on coping with depression. Depression can vary in how individuals experience symptoms. Family support and understanding can be a useful resource to cope with major depressive disorder. Individuals with depression may have difficulty recognizing signs of depression. Family can provide positive reinforcement, offer assistance and can help encourage participation in treatment. Alternatively, individuals may also use concepts of familismo as a protective factor against acknowledging and treating major depressive disorder. In the Latino culture, concepts of familismo, family is emphasized in terms of respect, support and obligation (Valdivieso-Mora, Peet, Garnier, Salazar & Johnson, 2016). In a study conducted by Valdivieso-Mora, Peet, Garnier, Salazar & Johnson (2016), they found presence of moderator variables between familismo and outcomes in mental health such

as communication. The influence of familismo paradox as used by participants to cope with major depressive disorder are stated as follows:

Participant #1 stated,

> I think my oldest daughter can tell me when I'm getting depressed or when I'm acting different. I kept telling her that everyone gets sad. Now I know that it's not the same. I still think my husband has depression. I keep telling him that he does because I know how it feels.

Participant #2 stated,

> I only have my brother here in Houston and we don't talk a lot. His son comes and gives me money and comes visit with me. I don't think they have a role, no, they don't have a role. They always tell me I'm going to visit and I'm going to visit but nothing. I call my house in Cuba, talk to my grandma and mom and that's it. Maybe they keep me happy; is that what you mean, (Researcher clarified: Yes, do you feel that talking to your mom and grandmother back home helps you cope with depression). Yes, they are very**,** very helpful. No matter what time I call, they are always there for me.

Participant #3 stated,

> My husband was with me when my doctor told me to see someone because I have depression. He actually put on the paper that I have depression. The doctor said it was a good idea that my husband was with me and told me that maybe he can see things that I don't. My husband said that there are times that he sees me sad or he tells me that I'm being mean. That is when I know that I need to do things like go

to my garden. I used to get mad at first but I think I can handle him telling me now. That's really how he helps me.

Participant #4 stated,

I talk to my daughter every day. How am I not, we live together. She picks me up when I'm down. She tells me are you sad and I always tell her no**,** but she knows sometimes. I tell her "ay mija" we all get sad. I just miss my other children sometimes**,** but she takes care of me.

My grandson is in college but when he comes**,** he tells me grandma let's do this and grandma let's do that. I tell him I'm tired**,** but he tells me I cannot say no. They are always checking to see if I'm ok, I think they know I miss my family. They are not here. (Researcher: Where is your family presently located?). They live in Mexico, by Raynosa. I call them sometimes but it's not the same.

Participant #5 stated,

I don't know what I would do without my family. This was nothing telling them I had depression. I think they knew**,** and they were helpful right from the beginning. It was more scary to tell them I had been with a woman than to tell them about my depression. I think deep down they thought I was just unhappy but now that they know, that are super super helpful, sometimes too much.

Sometimes we are eating**,** and they asked me. I tell them do not ask me right now (laughed) but I know it's because they care a lot for me.

Participant #6 stated:

I think that is a hard question for me, you ask me how my family helps but I have no family. I have no one. My husband did not want to come here**,** and I came with my mom and she died. I have no one. (Researcher: Is there extended family you speak to. Siblings, cousins, uncles). No, I have a brother**,** but he has his own life and stopped checking on the house when mom died. So**,** I guess they don't help at all. I don't tell them what is going on with me and they don't tell me about them. That's just how it is; and the worst part is that he is my twin. We should be close but he is just cares about himself. Even his kids think he is mean.

Participant #7 stated,

If my sons are happy, I'm happy. I think when the doctor told me I was depressed is because my son had a drinking problem. Oh**,** I would stay up all night scared that he was not going to come home**,** and my other son knew that and then they would fight. My husband died 12-years ago**,** and I only have my kids. They don't know I see the head doctor. Last year we were driving**,** and we got into an accident, me and my son, and we were ok**,** but he prayed and prayed and thanked God and he has not drank since and has a good job. Oh**,** that makes me so happy. No, I don't want to worry them, I just stay home and go to church when I want to get out.

Participant #8 stated,

I think telling my family is the most important thing I did. I think they helped me with everything. Yes, they are so worried sometimes when I want to stay home or

> ask me questions about my doctor and medicine, but I tell them. They worry a lot. I think they worry more if I did not tell them. We talk about it a lot. I don't mind.

Family inclusion is an important factor in individual's ability to cope with major depressive disorder. Social support and individuals coping style helped individuals adapt to treatment and influenced their overall health. Participants explored how they utilized family support to cope with major depressive disorder.

Theme 4. Impact of family inclusion when initially diagnosed with major depressive disorder. In the Latino culture, family support functions as a protective factor throughout crisis or psychological distress (Umana-Taylor et al., 2011). Familismo emerges as both a safeguard and hindrance to individuals coping with major depressive disorder. Experiences of participants as it relates to integrating family in assisting with major depressive disorder when initially diagnosed are indicated as follows.

Participant #1 stated,

> I had been feeling really low. I'm a very outgoing person, if someone is there**,** I'm talking to them but since my husband had a stroke things changes and he changed. He just stays home. His depression made me depressed. I went to see my doctor and they gave me a form to fill out and she tells me I have depression. I told her not {participant stated her full name}, I told her what is going on at home and she told me to see someone. My daughter found my therapist. They all know I go. I wanted my kids to know and maybe they can tell their dad to go too but he will not. He is just a stubborn old man. He is 86. I think telling my kids has really

helped me because they come more and that makes their dad happy and then I'm happy.

Participant #2 stated,

I'm here all alone. I have neighbor friends and I did not want them to think I was crazy. My mom said go go, you can get help and they give you medicine and stuff. I called my mom when I went.

I think listening to my mom and talking to her everyday helps. I take medicine, I think 25mg of Lexapro. I still take tea also to help me. I don't know if medicine does a lot of change but I take it. I tell her when I go to the doctor.

Participant #3 stated,

My family is everything to me. I want them to be happy, I want them to be safe. When they worry about me it makes me feel bad.

I do not know if it was important for my family to know I was getting help but I knew it was important. They know I'm sad but not how sad so telling them helped but I hate that they worry. But I think it is very important that I tell them after I went to the psychiatrist.

Participant #4 stated,

If it was important for my family to know. Well my daughter took me to the doctor**,** and they told her first because I don't speak English. I told my daughter, what did he say? (short chuckle). I told her depression? Medicine?..... no**,** no**,** no, I said No that I don't need them and no, I'm not depressed.

I'm glad that I went to the doctor and got help but I don't agree. I'm not taking medicine and my daughter stopped fighting me on it but like I said she does check on me a lot.

Participant #5 stated,

My family does influence my going to the psychiatrist. They take me, they take me to Walgreens**,** and they talk to me. At first**,** I did not want to go but I did so they stop annoying me and I'm a little glad I went. I talk to this very nice doctor. (Researcher: Can you clarify if by doctor you mean therapist or psychologist or psychiatrist).

Participant responds: I see both. I see the psychiatrist every 3-6 months and the therapist, let me see, I think about twice a month. Yes, twice a month. My daughter called my insurance and found them.

Participant #6 stated,

Thinking of my family makes me depressed. They know that I have depression; especially after losing mom and I don't think they care. I get mad because I'm the one calling all the time, if I do not call, I would never hear from them. They don't care. The lady that comes twice a week asked me more about my mood and how I'm doing that my own family.

Participant #7 stated,

Every Sunday we get together for lunch and that makes me so happy. They tell me all the time, mom you have to go out, mom you have to make friends. I tell them that I'm too old and just let me be at home. I like staying home and cleaning

it. My husband never let me change things and now I can**,** and I tell them to just let me do it. They don't know anything about my depression. I do not tell them what is going on with me. I think I will be fine, I even stopped taking the medication the doctor game me because I'm fine.

Participant #8 stated,

My family knows. I have been very open about my beliefs and my guidance. I understood something was not right with me. I felt off. My cousin is a therapist and she told me to see someone. My family is helpful. I drink tea's and make different oils because I'm not taking medicine.

Researcher: Can you clarify. Are these tea to help with mood or what type of oils

Participant: I really watch what I put in my body so when they told me medicine**,** I said no but I was doing herbs and holistic things. I understood I had depression but with the positive energy from my family and my guidance, I think that has helped me the most.

In the initial stages of mental health treatment, family can be of comfort and beneficial. Participants explored the influence disclosure to family had or has had on their treatment. Cohesive and inclusive family dynamic played a vital role in reducing depression among this group. Family encouraged the utilization of mental health treatment services in addition to effective use of coping skills.

Results

Data collection and analysis were based on the foundation question which is: What are the lived experiences of Latino women, 50-75, who have been diagnosed with

depression, and how they use familismo to cope with daily living. Chapter 4 focused on the study findings from data collected from eight participants who are diagnosed with major depressive disorder. The overall purpose of the study was to gain an understanding on how cultural concepts of familismo are used as a coping mechanism to manage major depressive disorder.

When analyzing collected data, it was evident that most participants utilized the concept of familismo as protective factors to confront depression. One participant, although fully engaged with her family employed cultural values as her responsibility to shield them from distress and anguish regarding her wellbeing.

Participant were able to develop coping strategies to warrant positive experiences and outcomes when managing depression. To help sustain positive outcomes, most participants utilized concepts of familismo to cope with depression. Familismo involves interactions between family members. Seven out of 8 participants demonstrated the use of familismo as an effective coping strategy to cope with challenges associated with major depressive disorder. Seven participants found that family support, and in return family's loyalty, is a necessary coping strategy. Seven out of eight participants utilized emotion-focused coping. This style of coping attempts to diminish negative emotional responses triggered by major depressive disorder. These included: seeking of emotional social support, positive reinterpretation, acceptance.

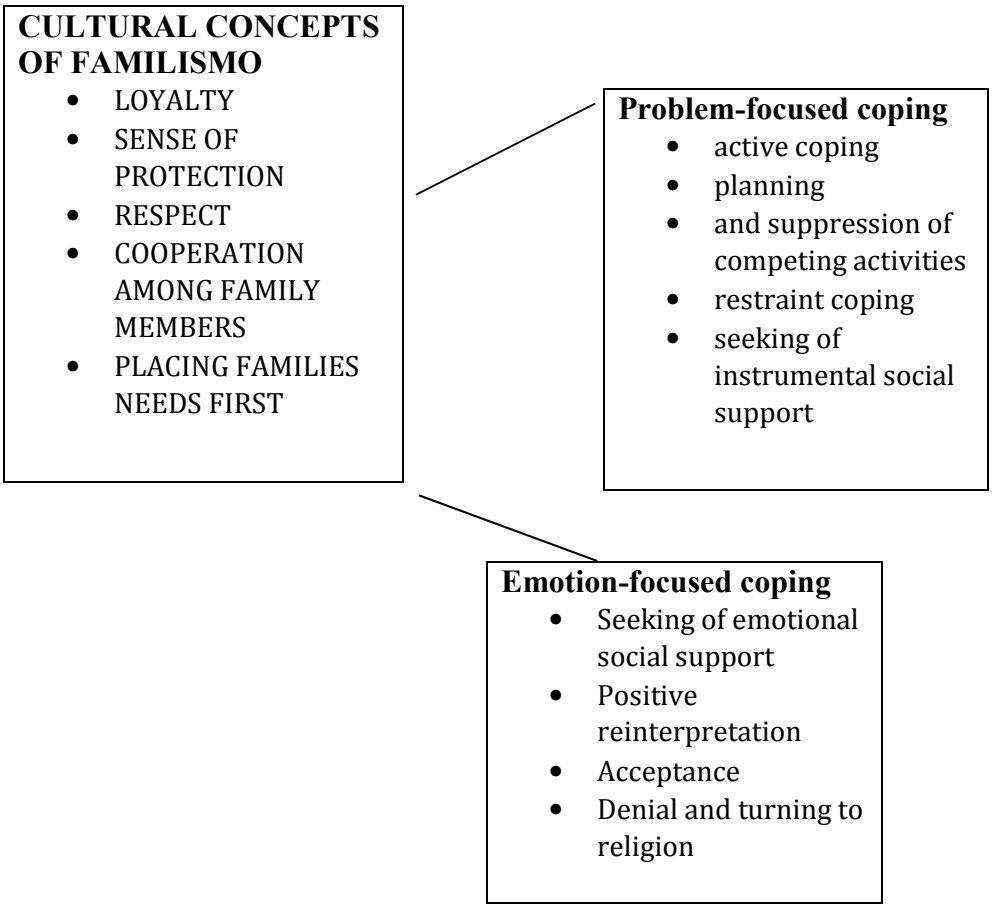

Figure 3. Concepts of familismo and types of coping skills.

Although I encountered difference in patterns regarding use of coping skills with diverse aspects of implementation and communication, disclosure in the initial stages appears to be critical for family involvement. Routine use of coping skills included calling family, engaging family during difficult times and engaging family in their treatment. Research findings indicated that there is a relationship between the use of familismo as a coping skill and positive outcomes when managing symptoms of major depressive disorder. Two participants identified that familismo had a direct impact on their decision to internalize their mental health diagnosis. These 2 participants reported

that perceived fear and their need to safeguard their family directed effected their decision to not disclose or not fully inform family of their mental health diagnosis or treatment.

Evidence of Trustworthiness

In Chapter 3**,** I outlined criteria used to ensure trustworthiness in a qualitative study which includes credibility, transferability, dependability and conformability. To ensure credibility, the truth of the study and its findings, I authenticated the transcripts with each participant to ensure accuracy. All participants acknowledged, authorized and stated accuracy of transcripts to ensure accuracy of their views. Furthermore, data analysis and data collection were conducted simultaneously to distinguish themes and data saturation. To ensure transferability and dependability, I provided an extensive account and detailed the methods used for conducting this study. This assures that this study could be employed in additional settings. Lastly, to guarantee confirmability, I used a reflexive journaling and bracketing to prevent prejudices or presumptions that may influence the study. Reflexivity journaling was used throughout the whole process.

Summary

The purpose of the study was to explore lived experiences of elderly Latina women on how they utilized concepts of familismo to cope with major depressive disorder. Chapter 4 provides the findings from 8 participants selected to participate in the study. Each participant was selected utilizing purposeful sampling. Participant selection strategies are outlines in both Chapter 1 and Chapter 4. Prior to data collection participant

were given consent forms to sign. To maintain confidentiality, each participant was given and ID code (P1 –P8). Participant responses were utilized to explore this phenomenon.

Four major themes emerged from the answers provided when questionnaire tool was implemented during interviews. Themes included 1) Acknowledging major depressive disorder 2) Impact of behavioral and emotional changes since deciding to disclose diagnosis to family 3) Influence and role family support has on coping with depression 4) Impact of family inclusion when initially diagnosed with major depressive disorder.

Participants' experiences revealed that cultural concepts of familismo are used as emotion-focused coping skills to manage major depressive disorder. The majority of the participants disclosed that family support and family encouragement were critical components in being able to manage major depressive disorder and engage in mental health treatment. Chapter 5 will further interpret the findings. Limitations, recommendations and implications for social change will be comprehensively discussed in Chapter 5.

Chapter 5: Discussion, Conclusion, and Recommendations

Introduction

In this study, I explored the experience of Latino woman between the ages of 50 and 75 in Houston, Texas, and the use of cultural concepts of familismo to cope with major depressive disorder among elderly. This study was based on the experiences of eight Latino women who met inclusion criteria for the study. The study was conducted to explore and adopt effective skills to cope with depression among this specific population.

With the aging population growing rapidly, mental health challenges need to be recognized. The WHO (n.d.) estimates that the elderly population will double from 12% to 22% by 2050. With the Latino population increasing in the United States, mental health outcomes should be analyzed. Depression is the most prevalent mental health disorder affecting 7% of this specific population. Care strategies are important to effectively address mental health needs. It is critical to promote effective intervention training among all mental health professionals.

Among the elderly Latino women, familismo is a key factor for health promotion. Research shows that familismo in the Latino culture emphasizes family relationship. This paradox can help health mental health professionals understand critical factors that should be addressed during treatment planning. Immersing myself in the participants' interviews granted me access to their experiences and allowed me to gain insight into how concepts of familismo are used in participants' daily lives to cope with major depressive disorder. Data collected from this study will help prepare mental health

professionals in various levels develop effective treatment plans and procedures to address major depressive disorder among elderly Latino women.

In this chapter, interpretation of findings will be discussed. I will be using research questions, emerging themes, conceptual framework and literature review as guidance. In this chapter, I will discuss limitation of the research, provide recommendations and discuss implications to social change.

Interpretation of Findings

The research centered on this question: What are the lived experiences of Latino woman between the ages of 50 and 75 with using concepts of familismo to cope with major depressive disorder? In Chapter 2, concepts of familismo and two types of coping skills were discussed in depth. It has been established that, in the Latino culture, family functions as a pivotal component which shapes cultural values (Valdivieso-Mora et al., 2016). Valdivieso-Mora et al. (2016) stated that familismo is associated with mental health in the Latino culture and family connection has a positive effect on mental health.

From the interviews, four themes materialized. The themes were (a) acknowledging major depressive disorder, (b) impact of behavioral and emotional changes since deciding to disclose diagnosis to family, (c) influence and role family support has on coping with depression, and (d) impact of family inclusion when initially diagnosed with major depressive disorder.

With the exclusion of P7, all participants had disclosed their mental health diagnosis and utilized family as an effective skill to cope with symptoms of major depressive disorder. P1, P2, P3, P4, P5, P6 and P8 openly discussed experiences

regarding initial reaction to diagnosis and decision to disclose to family. All participants, with the exclusion of P7, indicated that disclosing their mental health diagnosis was stressful but helpful. All participants with the exclusion of P7 reported that family members were supportive, and lack of knowledge and stigma were factors that they explored as they decided to disclose their diagnosis. P7 noted that it is important for her to conceal her family from her diagnosis. Consistent with earlier research findings, there are several issues to consider regarding why Latinos may not seek treatment. As experienced by P7, she protects her family by not disclosing diagnosis.

P7 stated, "I never want my family to know. I never want them to have to worry about me. I am their mom, I have lived alone since my husband died. I take care of them. . . . They don't know I take medicine. Ohh no no no, they will not know."

Consistent with putting family's needs before one's own, P7 still implements concepts of familismo. Along with familismo, it should be noted that cultural beliefs, norms, and values were noted throughout interviews. Natural medicine (including home remedies) and faith and spirituality are additional cultural skills used to cope and support treatment of major depressive disorder. It is highly suggested individuals speak with their mental health professional or primary care physician to make healing practices part of the treatment plan as effective treatment approaches can be combined (National Alliance on Mental Illness, n.d.). P8 stated, "I go to church, I try to help when I can. My kids work so when I feel alone, I just go. Sometimes I do go out with the sisters but most of the time I go for me." P8 also stated, "my sister sends me "hierbas" and that's what I make my teas from. I'm not taking medicine." P7 stated, "nobody knows that I saw a doctor and they

gave me medicine. On Sundays and Wednesdays, I got to church and that helps me. My son tells me when I'm sad, lets go to church mom."

It was noted that many of the participants used concepts of familismo to cope with major depressive disorder. For several of the individuals interviewed, they felt that family involvement is a vital element in their mental health treatment. They utilized family support to engage in treatment and continue a healthy lifestyle. Participants explained experiences of how family involvement helps daily.

Theoretical and Conceptual Framework Considerations

From the interviews, it was evident that emotion-focused coping strategies are widely used among participants to cope with major depressive disorder. Exploration of participants' lived experiences suggested that among Latino elderly women, emotions and social support are the preferred coping strategies. This includes concepts of familismo that primarily focused on the care and interdependence of family support. Each interview question asked centered on family involvement in their treatment, day-to-day life and experienced when they disclosed diagnosis.

The decision to use coping skills theory was appropriate for the study. This framework helped comprehend experiences of Latino women between the ages of 50 and 75 and the use of family, cultural values, and belief as a skill to cope with major depressive disorder. This framework allowed for a better understanding of the lived experiences of the participants as it relates to cultural concepts of familismo.

Limitations of the Study

The primary focus of the study was to gain understanding on how cultural concepts of familismo are used to cope with major depressive disorder among the elderly Latino population. To further understand this phenomenon, data gathered for this study were unique to this specific group. This study presents with several limitations.

A limitation is the geographical location where this study was held. All participants from this study presently reside in Houston, Texas; therefore, there is a limitation in generalizability to other Latino women who are between the ages of 50 and 75 diagnosed with major depressive disorder. Consequently, findings may not be valid for the general population that otherwise meets the inclusion criteria. With Latinos making up 45% of Texas residents, experiences of elderly Latino women may differ in other geographical regions. Agencies used to recruit participants are also unique as they serve this specific region. Another limitation is the sample size used for this study. The findings of this study are experiences of only eight Latino women, aged 50-75, diagnosed with major depressive disorder residing in Houston, Texas.

The sample population and size itself presents as a limitation. This study explored the lived experiences of eight Latino elderly women. This study included Latino women from various backgrounds (i.e., Mexican, Cuban, Puerto Rican, and Salvadoran). This study did not encompass additional Latino cultures such as Dominican, Central American or South American. Participants in different ethnic backgrounds may not encounter similar experiences or implement familismo as those that were interviewed. Therefore,

along with not being able to generalize findings, results may not a good reflection of the Latino population.

Although I adopted bracketing in the data collection and analysis process by maintaining a reflexivity journal, being part of the culture under research could inadvertently introduce bias into the research. Employing bracketing allowed me to set aside my own belief about the phenomenon and dismiss what I already knew about the subject before and throughout the phenomenological investigation (Chan, Fung, & Chien, 2013). Bracketing also helped ensure that I did not affect the participants' understanding of the phenomenon. (Chan et al., 2013). I made efforts to put aside predispositions, knowledge, and beliefs of the phenomena being investigated, but Chan et al. (2013) advised that pre-understanding cannot be fully eliminated or bracketed.

Recommendations

There is limited understanding and focus on the experiences of older Latino women and the use of familismo to cope with major depressive disorder. Past and current research does not include this unique population; therefore, this study addresses the gap in literature.

It is recommended that further qualitative studies be conducted to bring attention to effective ways to overcome mental illnesses. Future researchers may want to include various backgrounds to further explore relevant cultural factors that can further be implemented in mental health treatment. It is recommended that future researchers include male elderly Latino for further evaluation of the use of familismo to cope with major depressive disorder.

There is extensive research focused on prevalence of mental health disorders among the Latino ethnic group but trivial research on skills that would be effective to treat mental health. This research provided insight on how elderly Latino women utilize familismo as a skill to cope with major depressive disorder. With only 20% of Latinos discussing mental health to their primary care physicians (National Alliance on Mental Illness, n.d.), it is recommended that physicians and mental health professionals begin collaborating and encouraging family involvement. Because Latinos have strong family cohesiveness, as seen in the research, family support can embolden individuals to address and treat their mental illness.

It is critical to illuminate the need to provide sensitive and culturally competent treatment among professionals. In the study, I was able to reveal that there is a relationship between the use of familismo and emotion focused coping. The results indicated that elderly Latino females rely on family for support to ensure everyone's wellbeing and vice versa, they did not disclose diagnosis to ensure wellbeing on their family. It is recommended that mental health professionals implement culturally competent coping skills to improve outcomes of treatment. This includes encouraging use of family and cultural beliefs when developing mental health treatment plan with an elderly Latino woman.

Implications for Social Change

Strong cohesiveness can be viewed as a positive or negative attribute in the Latino culture but should be considered as it gravely effects the individual. Change is inevitable and therefore practitioners and mental health professionals should attempt to shape and

create changes that results in constructive outcomes. This study showed that Latino women between the ages of 50 and 75 had strong positive experiences when family was included in the treatment. These results indicate that familismo, and the way of life in the Latino culture should be discussed when developing treatment plans for these specific individuals.

In order to create lasting outcomes, mental health practitioners should take note on life experiences and develop effective way to incorporate family, cultural concepts and cultural values to make significant social changes. Development and growth in the therapeutic community on how to effectively help patients cope with major depressive disorder is a change that requires further consideration. Changes in the social structure as it relates to mental health requires accepting cultural development. Comprehending cultural differences, such as familismo promotes advancement and collective advancement to target and treat mental health effectively. This study and its findings can help identify considerations of social change in mental health when working with this vulnerable population.

Conclusion

Mental health is critical in every stage of life. The purpose of this research study was to explore the experiences of elderly Latino women and the use of familismo to cope with major depressive disorder. I addressed the literature gap regarding the relationship between the use of familismo to cope with major depressive disorder among elderly Latino women between the ages of 50 and 75. This study concluded that elderly Latino women between the ages of 50 and 75 use concepts of familismo to cope with major

depressive disorder. Their experiences showed a structure consistent with emotion□ focused coping mechanism. This research study will further help mental health professionals develop effective treatment plans among this population.

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Appendix A: Demographic Form

Name: _____ Phone Number: _____

Address: _____

Gender: ☐ Female ☐ Male

Age: ☐ 50-64 ☐ 65-70

Marital Status: ☐Married ☐ Divorced ☐ Widowed ☐ Separated

Do you have family reside in the same city as you? ☐ Yes ☐ No

Are you from Latino descent? ☐ Yes ☐ No **Please Specify**: _____

Native Language? ☐ English ☐ Spanish ☐ Other _____

Language spoken in your home (check all that apply) ☐ English ☐ Spanish ☐ Other _____

When were you diagnosed with major depressive disorder? Year _____

Do you currently have a mental health provider? ☐ Yes ☐ No

Are you currently engaged in mental health treatment? ☐ Yes ☐ No

Education Level Completed: _____

Occupation: _____

How would you describe your family support? _____

Appendix B: Interview Questions

Participant ID_____ Date of Interview _____

Gender _____ Race _____ Age_____ Marital status _____

Consent signed _____ Consent copy given to participant _____

1. How long have you been diagnosed with depression?

2. Was your family informed when you decided to seek mental health treatment? What encouraged/ prevented you from telling family?

3. Can you tell what factors that encouraged you to seek mental health services?

4. What are your beliefs about depression?

5. Have you discussed your major depressive disorder diagnosis with your family?

6. Do you feel that disclosing your diagnosis with your family has helped you cope with the diagnosis?

7. How do you utilize your family to cope with major depressive disorder?

8. Do you feel as if there is a difference of how your family treats you now that they know?

9. What has been your family's interaction with you since disclosing that you are in mental health treatment?

10. Tell me about the role your family has on your mental health treatment.

11. What was the most difficult part of telling your family?

12 . Tell me how important was for you that your family know you are seeking mental health treatment.

13. Can you tell me if your family has an influence on your treatment? If so, can you elaborate?

14. How do you view yourself now since seeking mental health treatment?

15. Can you tell me what prevented you from seeking treatment in the past?

16. Has your views regarding depression changed since you disclosed diagnosed to your family?