2022

The Effectiveness of Culturally Specific Interventions on Young Adult Latina Women

CHERYL DENISE SMITH
Walden University

Walden University

College of Psychology and Community Services

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Cheryl Denise Smith

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Review Committee
Dr. Kimberly Farris, Committee Chairperson,
Human and Social Services Faculty

Dr. Curt Sobolewski, Committee Member,
Human and Social Services Faculty

Dr. Scott Hershberger, University Reviewer,
Human and Social Services Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
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Abstract

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Dissertation Submitted in Partial Fulfillment

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Doctor of Philosophy

Human Services - General Program

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Abstract

Using culturally specific interventions to provide mental health support to young adult Latina women may improve mental healthcare results by furnishing resources that are culturally competent and inclusive. Young adult Latina women continue to experience disparities with mental healthcare resources such as cultural adaptability and accessibility. The purpose of this phenomenological qualitative study was to explore how culturally specific interventions could result in mental healthcare supports for young adult Latina women who are experiencing mental health issues such as depression and anxiety. Bronfenbrenner's ecological system theory was used as the conceptual framework. Purposeful sampling was used to recruit 12 young adult Latina women who resided in one of the five boroughs in New York City. Semi structured interviews were used to collect data. Interpretive phenomenological analysis was used to analyze the data. Eight themes were identified. The young adult Latina women identified a lack of cultural competence in the mental health field as a contributor to issues with engagement with mental healthcare resources. A significant finding was the young adult women acknowledged the role they played in creating a barrier to engaging with mental health resources. A revelation was that participants believed mental healthcare would be helpful to their well-being. One recommendation was that young adult Latina women be given more access to information on symptoms of mental health issues to identify them sooner and begin seeking help. The findings are potentially useful positive social change for practitioners and policymakers to create culturally specific interventions to help improve the mental health outcomes for young adult Latina women.

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Dedication

My dissertation is dedicated to my mother Mildred Smith, may she continue to rest in peace, and my son Shomari Mikal Smith. To my mother because she showed me strength and taught me determination. I know that you are looking down on me and I pray that I have made you proud. To my son, I pray that I have shown you strength and taught you determination. I pray that you are as proud of me as I am of you. Just know that you can achieve anything you want in this life and remember to always be proud of yourself.

Acknowledgments

First, I would like to thank Dr. Kimberly Farris, my chair. From the moment we were placed together, you were a great source of encouragement, knowledge, and motivation. Thank you for all of your help in completing this awesome journey. Dr. Sobolewski, my 2nd committee member, thank you for your advice and encouragement. You helped in making this a less stressful journey.

Thank you to my friends and family members who showed me support and understanding. Finally, I would like to thank my best friend Clyde Davison (nickname My Muffin). Thank you for never wavering in your support. Thank you for coming with me to every residency. Thank you for motivating me when I needed it and thank you most of all for being my best friend.

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Chapter 1: Introduction to the Study

Introduction

Cultural adaptation is the methodical alteration of an evidence-based intervention (Fendt-Newlin et al., 2020). Specialists engage in cultural adaptation to consider a person's language, culture, and their context in such a way that is compatible with the person's cultural patterns, meaning, and values (Fendt-Newlin et al., 2020; Dillon et al., 2018). By understanding of person's cultural background and adapting to it, specialists can develop trust and accountability with that person (Dillon et al., 2018).

As individuals from different cultural backgrounds find it difficult to locate healthcare resources to meet their cultural and mental health needs, research studies that respond to the importance of culturally specific treatments that focus on developing trust with patients are still lacking (Fendt-Newlin et al., 2020). Therefore, there remains a need to consider culturally specific interventions, as opposed to traditional generalized interventions when providing healthcare to people with different cultural backgrounds (Fendt-Newlin et al., 2020).

Culturally responsive healthcare practices should be a more recognized by mental healthcare practioners to enhance the healthcare services that are delivered to people with different cultural backgrounds (Fendt-Newlin et al., 2020). Particularly, when the goal is to reduce health disparities in ethnic groups, culturally adapted interventions can demonstrate a healthcare provider's consideration for a client's identification, values, and culture (Cramer & Castro-Olivo, 2016; Fendt-Newlin et al., 2020). Culturally adapted interventions can also increase a provider's potential to bridge the disconnect between the

provider and the cultural community they are servicing, which in turn can strengthen the engagement of members in the ethnic groups (Cramer & Castro-Olivo, 2016; Fendt-Newlin et al., 2020).

Young adult Latinas experience the challenge of securing unbiased healthcare access because of obstacles such as their immigrant class, their socioeconomic class, and unplanned hurdles in the healthcare system (Dillon et al., 2018). Because young adult Latinas have been a large and growing population in the United States, there has been a considerable need for psychologists to attend to their psychological distress such as the frequency, intensity, and different types of psychological symptoms, such as depression and anxiety (Dillon et al., 2018). Rates of depression have been higher for Latina women in comparison to non-Latina White women, and more than one-third of Latinas in the United States have experienced depressive symptoms (Dillon et al., 2019).

Psychological distress includes emotional, cognitive, behavioral, and psychophysiological symptoms that are related to a mental disorder or illness, and identified psychological distress as inherent in human behavior, independent of sociocultural background, and present across all forms of illnesses (Barragán et al., 2019). Standards on the appearance of mental suffering can change between ethnic sets (Ramos-Sanchez, 2020). Latinas may experience psychological suffering with noticeable features such as nervousness (Barragán et al., 2019). Mental health providers should be encouraged to broaden their knowledge of community resources and increase their advocacy for young adult Latina women (Ramos-Sánchez, 2020).

Young adult Latinas fall below the national average when it comes to education, income, and employment, causing an increased amount of stress, which can manifest into poor physical and mental health conditions (Bruzelius & Baum, 2019). Evidence-based interventions for treating mental health conditions must be improved in order to address the mental health treatment gap among young adult Latinas (Fendt-Newlin et al., 2020). Most psychological interventions for the treatment of mental health conditions have been developed for a generalized use (Fendt-Newlin et al., 2020).

Background

As the young adult Latina population grows, promoting their healthy transitions into U.S. society has increasingly become a necessity for psychologists (Dillon et al., 2019). The healthcare field has a responsibility to monitor and include multilevel facilitators by way of outreach efforts and treatments to better assess and understand what specific factors can be used to improve the well-being of young adult Latina women (Ring, 2020). My goal for this study was to narrow the gap in current knowledge regarding the importance of social and cultural contributing factors to psychological distress among young adult Latina women.

Exploring Latina cultural values may result in findings that healthcare professionals can use to understand potential ways to reduce and eventually eliminate current mental health disparities, such as depression, suicide, and other mental health problems (Dillon et al., 2019). Health disparities created by socioeconomic factors are even more complicated by discrimination by healthcare professionals and language barriers that result from a lack of qualified interpreters and bilingual providers (Bruzelius

& Baum, 2019). This situation creates a cultural divide in which young adult Latina women who are less comfortable speaking English are more likely to turn to alternative forms of support, such as religious and community institutions (Estrada-Martínez et al.,, 2019). Increasing cultural competence in healthcare providers, designing and delivering culturally specific healthcare tools, connecting language access to patient safety and quality of care, and encouraging connections within cultural communities are ways to decrease the challenges faced by young adult Latinas in healthcare (Fendt-Newlin et al., 2020).

Statement of Problem

Despite the growth in this population, services in healthcare and education have not expanded to meet the needs of this flourishing, diverse population (Ruiz et al., 2016). For the Latin population, disparities are found in the availability and accessibility of healthcare, mental health, and educational opportunities for young adult Latina women residing in the United States (Ruiz et al., 2016). As previously mentioned, birth rates are also the highest within the Latina population in the United States (Pew Research, 2019). Non-Hispanic White birthrates were 55.3, non-Hispanic Black was 61.4, and Hispanic were 65.3 (Centers for Disease Control, 2019). The limited response to meet the needs of this population has likely contributed to the disparities faced by the Latin population. Disparities are defined as health conditions that are unequal to some degree, including factors that are associated with differential rates of disease for a subgroup or population (Cabeza de Baca et al., 2018).

In addition to health, mental health is rarely discussed in the Latin community as there is little knowledge in this community on the topic (Barnett et al., 2016). An individual cannot seek help for something they do not recognize as an issue (Barnett et al., 2016). They do not have any knowledge of signs or symptoms, or where to find treatment for mental health issues (Barnett et al., 2016). There is a stigma associated with mental health issues within the Latin community that brings shame to an individual and their family. Unfortunately, the lack of knowledge increases the stigma around mental illness (Pintar Breen et al., 2018).

It is exceedingly difficult for some people to even consider seeking help from a mental health professional (Ruiz et al., 2016). While expressing difficulty in combatting mental health issues, young adult Latina mothers may be dismissed as being too emotional. This sharing of their feelings may leave any productive conversation about changing their circumstances out of the question (Pintar Breen et al., 2018).

A person's beliefs, norms, values, and language play a significant role in every aspect of their life, including mental health (Cabeza de Baca et al., 2018). Culturally adapted intervention programs, as well as culturally competent practitioners' identification of social science principles, are critical to the mental health stability of young adult Latina women. Unfortunately, research has shown a lack of evidence-based culturally adapted interventions focused on mental health care for young adult Latina women (Shuey & Leventhal, 2018).

Several reasons prevent young adult Latina women from receiving support services (Ha & Ybarra 2014). The inequality in treatment and nonreceipt of treatment

places young adult Latina women at a higher risk for continued mental health issues (Cabeza de Baca et al., 2018). Young adult Latina women are just as susceptible to mental health issues just as any other group of individuals (Ruiz et al., 2016). However, issues that arise in the disparities that are experienced by young adult Latina women include limited access to support services and services that have not been culturally adapted to provide optimal support (Ruiz et al., 2016). There is a great misunderstanding in the Latin community about receiving proper healthcare, for themselves as well as their children (Cabeza de Baca et al., 2018). Many young adult Latina women only speak Spanish and are not fluent in English, which can cause issues when attempting to seek out help (Pintar Breen et al., 2018).

People within the Latin community are very private, and many issues are not discussed outside of the home (Shuey & Leventhal, 2018). Challenges such as mental health issues are typically not discussed in or outside of the family home in the Latin culture so as not to stigmatize or bring indignity to the family (Garcia & Duckett, 2009). The language barrier that many Latinas have creates a problem when communicating with doctors (Garcia & Duckett, 2009; Shuey & Leventhal, 2018). Latinas who are not bilingual and do not have access to an interpreter during doctor visits can find a healthcare facility very intimidating and choose not to use healthcare services, which could cause lingering mental health issues (Garcia & Duckett, 2009; Shuey & Leventhal, 2018).

Some doctors may be bilingual; however, they still may not be aware of how to address cultural issues that have the potential to lead to misdiagnosis (Pintar Breen et al.,

2018). For example, a young adult Latina woman may explain to the doctor that she is tired or maybe nervous, which medically could also be viewed as depression, but a doctor who is not aware of the influence culture has on the mental health of young adult Latina women could miss the signs of depression (Pintar Breen et al., 2018). The expectations of what makes an acceptable Latina is often rooted in behavior and maintaining appearances, specifically when it involves something as personal as mental health or illness (Ruiz et al., 2016). Young adult Latina women experience high levels of stress and conflict with their parents due to differences in upbringing (Pintar Breen et al., 2018), which plays a significant role in Latina suicide attempts (Pintar Breen et al., 2018).

Many young adult Latinas, who were born in the United States have parents who were born in Latin countries. They are grounded in collectivistic beliefs and preferences such as respect for the cultural values they have been brought up with. Strong family respect and respect for the people in their community are very important to them. (Garcia & Duckett, 2009; Toro & Nieri, 2018). However, these young adult Latinas living in the United States have been exposed to individualistic beliefs such as being responsible only for themselves, and many have conformed to individualism (Garcia & Duckett, 2009; Toro & Nieri, 2018). These women still must deal with the consequences of not following the cultural values of their parents (Garcia & Duckett, 2009). Being cast aside by one's family, no longer being accepted, and bringing shame to a family can cause a person to experience mental health issues such as stress and depression (Garcia & Duckett, 2009; Toro & Nieri, 2018).

Mental Health Issues with Latinos

Mental health is key to physical health, social relationships, and economic mobility during adulthood (Estrada-Martinez et al., 2019). Latinos are the largest minority group in the United States, and these individuals have some of the poorest health outcomes and highest rates of mental distress in the United States (Estrada-Martinez et al., 2019). Access to quality mental healthcare should be a priority and ongoing concern for individuals, communities, healthcare facilities, and local, state, and national governments (Garcia & Duckett, 2009).

Little to no access to mental healthcare services has contributed to prolonged disparities such as depression, post-traumatic stress disorder, and anxiety, that young adult Latina women have been experiencing with mental health (Garcia & Duckett, 2009). Removing the stigmas Latinas associate with mental healthcare such as being weak and other labels like crazy can play a significant role in decreasing mental health disparities (Garcia & Duckett, 2009; Hofmann et al., 2020). Breaking down language barriers, providing Latinas with culturally competent services, and educating young adult Latina women on the biological aspects of mental health disorders could help to normalize discussions on mental health and encourage them to be more inclined to seek out services that could help end the mental health suffering that they often do in silence (Garcia & Duckett, 2009; Hofmann et al., 2020).

Understanding the effectiveness of culturally adapted interventions to support mental health is critical as the Latino populations are underserved regarding mental health; therefore, healthcare providers should address the degree of cultural relevancy in

the makeup and approach of healthcare services to young adult Latina women (Fendt-Newlin et al., 2020). Many Latinos are faced with socioeconomic, educational, cultural, behavioral factors, and limited access to services. These can create difficulties in their attempts to improve their mental health, and well-being, These adverse experiences can created a sense of mistrust and fear. The fear of being discriminated against could also make it difficult for them to ask for assistance (Flynn et al., 2020).

Socioeconomic, educational, cultural, and behavioral factors and limited access to services make it difficult for Latinos to improve their health and well-being (Flynn et al., 2020). Young adult Latina women have twice the risk of mental health issues as others within the Latino population group (Estrada-Martinez et al., 2019; Fedina et al., 2020; Ramos-Sánchez, 2020). Researchers have attributed this disparity to differences in exposure and inclination to stressors (Estrada-Martinez et al., 2019; Ramos-Sánchez, 2020).

Mental Health Issues with Young Adult Latina Women

Mental health issues occur due to a series of events. They may be the result of numerous associated causes such as lack of health insurance and misdiagnosis of health issues. Latinas may label a mental health issue as a physical issue; therefore, healthcare professionals should be aware of Latino cultural factors (Miles et al., 2018). When a person's mood, behaviors, or feelings are affected, these conditions are considered a mental illness (Miles et al., 2018).

These conditions could influence how an individual can relate to other people they meet or how they function in society daily (Hense et al.,2018). Mental health issues

could be brought on by influences such as the environment someone lives in, experiencing crime, or genetics (Gardner & Kerridge, 2019). Having a difficult housing situation and burnout from work can cause some people to have mental health issues (Gardner & Kerridge 2019). When appropriate mental health treatments are received, a person has a better chance of having a more significant life, especially when interventions are started early (Miles et al., 2018).

The Latino community in the United States varies and encompasses many different races which include Mexicans, Puerto Ricans, Cubans, Dominicans, Guatemalans, Salvadorans, and Colombians (Finno-Velasquez & Ogbonnaya, 2017). While many Latinos have resided in the United States for numerous years, other Latinos who are newcomers to the country may face unfairness in socioeconomic status, education, and access to healthcare services (Finno-Velasquez & Ogbonnaya, 2017). It has been reported that there is a significant number of Latinas that experience some form of mental illness which makes interventions that are culturally tailored an important issue. Young adult Latina mothers have cultural expectations placed upon them in which they are required to keep up appearances, especially in personal matters such as mental health (Ospina-Pinillos et al., 2018).

Young adult Latina mothers experience high levels of traumatic disorders, stress, and depression due to differences in cultural upbringing, which plays an important role in young adult Latina mothers' lives (Pintar Breen et al., 2018). It has been noted that young adult Latina mothers are less likely than non-Latino Caucasians to seek out supports to

help with mental health issues, especially when they usually can not recognize the signs of mental health issues or know where to find help for them (Shuey & Leventhal, 2018).

When young adult Latina mothers reveal that they are dealing with mental health issues, they may be dismissed as being overly emotional, which can rule out any conversation that may have been productive leading to a change in how these issues are viewed by those in their communities and the health field (Shuey & Leventhal, 2018). This perceived attitude makes it far too difficult for some to even consider seeking help from someone in the mental health field (Pintar Breen et al., 2018). Pressures from peers, family, and the community can lead to expectations too high levels of frustration and potentially have irreparable outcomes (Shuey & Leventhal, 2018).

It is imperative to the physical and mental well-being of young adult Latina mothers that conversations are had regarding the necessity of healthcare resources (Iorfino et al., 2019). Young adult Latina mothers struggle with numerous mental issues (Chase & Rousseau, 2018). These mental issues such as depression, stress, and trauma, can stem from lack of education, unstable housing, and newly residing in a different country (Iorfino et al., 2019). Inadequate resourced mental healthcare and numerous barriers to services can continue inequalities in the health field (Iorfino et al., 2019).

Many young adult Latina mothers are dealing with several different emotions (Chase & Rousseau, 2018). The possibility that they may not get the support that they need, to address the emotional issues they have, is very stressful. They need help from a mental health professional; however, they are concerned or reluctant to get help. The misunderstanding of the health field is a strong argument as to why more cultural

approaches need to used in the mental health field (Pintar Breen et al., 2018). Early identification of mental health issues is especially important to ensure that they have a good chance of achieving a positive outcome when they receive treatment (Gardner & Kerridge, 2019).

Mental Health Interventions

It is necessary to improve accessibility and standard of mental health interventions used to provide support to individuals who have been placed in a disadvantaged position due to their traumatic experiences based on their racial and ethnic groups. There is a pressing need to enhance the availability and quality of mental health services provided to individuals who are underprivileged based on their race-related group (Chase & Rousseau, 2018). Numerous researchers have recommended that conventional mental health therapies be altered to better help those in need of support with distinct cultural outlooks (Chase & Rousseau, 2018; Parra Cardona et al., 2012; Rodriguez, 2017).

With the Latin population continuously growing in the United States, the requirement to establish evidence-based cultural interventions to assist with any mental behavioral disorders they may be experiencing, has become significantly important to many healthcare professionals. The search for more effective evidence-based cultural interventions in healthcare has contributed to effective support for Latinas experiencing mental health behavioral issues (Pintar Breen et al., 2018). Interventions that are meant to address health and welfare issues or put a stop to these issues could lessen the risk for more harsh and continuing forms of mental health conditions (Iorfino et al.,2019).

Mental health conditions can become worse when the appropriate treatment is not received (Iorfino et al., 2019). Mental health interventions that are culturally tailored may be more personally applicable to young adult Latina mothers and assist them with addressing and coping with external issues (Ha et al., 2017). Among young adult Latina mothers, exposure to problem-solving therapy content and identifying personally relevant interventions have the potential to reduce mental health disparities by increasing engagement with mental health services (Ospina-Pinillos et al., 2018). It is argued that interventions that have been altered for a unique group may be better than traditional approaches and result in health services that are more effective for marginalized populations (Joag et al., 2020).

Purpose of Study

The purpose of this qualitative phenomenological study was to develop an understanding of how culturally specific interventions can result in support to young adult Latinas. The cultural, psychological, and language barriers experienced by this population may affect the use of required supports. In this study, I sought to better understand the perceptions of young adult Latinas regarding how they cope with adverse experiences and how this relates to culturally specific interventions.

Significance of Study

Culturally proficient social work is strengths based and grounded in principles that are focused on (Kulis et al., 2015). This study was necessary because of the stressors that young adult Latina women in the United States of America experience are not addressed in therapeutic settings. My goal for this study was to generate positive social

change by creating the opportunity for a discussion that results in a better understanding of young adult Latinas' perceptions of services they are seeking and receiving when seeking support.

This research is worthy of attention because it can be used by practitioners to alter practices and policies. It may also affect funding opportunities of organizations that apply for funding and resources for programs providing services to underserved populations such as young adult Latina women. This study also includes practical details for practitioners to expand on cooperative aims that support culturally specific interventions. I contributed to the literature in the field by detailing what young adult Latina women recognize could benefit from the use of culturally specific interventions.

Theoretical Framework

There is a growing momentum to combine strategies and information to inform policy and practice to encourage cultural competency when servicing clients from different cultural backgrounds (Cramer & Castro-Olivo, 2016). Practitioners who seek to provide positive and effective support to clients who come from diverse cultural backgrounds must include cultural norms of the client that shaped their views of the world they live in, with the traditional forms of interventions, to effectively help these clients (Li, 2016). Urie Bronfenbrenner's ecological systems theory, a conceptual framework that practitioners can use to view a person's developmental growth based on how they are influenced by the environments they interact in, will help provide practitioners with a lens for comprehending the importance of culturally tailored interventions (Bronfenbrenner, 1977; Marsiglia & Booth, 2015). This theory can

demonstrate how different influential aspects such as culture and society, which are interrelated, impact an individual's perception of adverse experiences (Marsiglia & Booth, 2015).

The ecological systems theory provides a lens for comprehending the procedures by which at-risk young adults prevail over adversity (Marsiglia & Booth, 2015). The theory also provides a conceptual framework for viewing and understanding why culturally specific interventions are necessary to help vulnerable people feel comfortable in intervention programs and continue to return to them (Marsiglia & Booth, 2015). Marsiglia & Booth (2015) notes this theory will be a guide for understanding how young adult Latina women can benefit from specific interventions and influence their capability to engage with tailored intervention programs. This theory aligns well with my research question since I will be analyzing how culturally specific interventions relate to the perceptions of young adult Latina women on how they cope with pressures (Marsiglia & Booth, 2015).

Research Question

The following research question was used to guide my phenomenological study: What role do culturally specific interventions play in healthcare initiatives used to address mental health issues experienced by young adult Latina women?

Nature of the Study

With the aim of phenomenology being to understand a social phenomenon, by way of the expressed perspectives of an individual’s lived experiences, the phenomenology approach will be used in this study (Knudson, 2015). The

phenomenological approach will assist me in gaining an understanding of the interrelated perspectives of the participants (Knudson, 2015), which will be used to demonstrate the need for more illumination on the phenomena of culturally specific interventions (Davidson, 2012). The data collection tool used for this study will be semi structured interviews (Lancaster, 2017). The interviewees for the study will be young adult Latina women between the ages of 18-35. They will be from the Latina cultural background (Kliewer, 2016). To ensure that there is enough data to support my study a sample size of 15 will be selected. As noted in Sheehan et al (2016), in the phenomenological study the sample range can be 6-10. I selected 15 to leave room for any unexpected recruitment challenges. The limitations of my study involve potential difficulty in engaging with my participants because they may be fearful of being exploited or misrepresented (Li, 2016). Other limitations to the study may be their concerns with confidentiality (Li, 2016). It will be the researcher's goal to maintain the welfare of each participant. The study may not apply to other social settings, and researcher bias may be difficult to avoid (Plamondon et al., 2015).

Ethical issues such as confidentiality and beneficence could present an issue for the study. Interviewer bias can also be an issue during the interview process; reflexivity must be used throughout the research study (Matteson & Lincoln, 2009). To establish credibility, which is an important criterion of trustworthiness, triangulation will be used to check the consistency of the findings (Amankwaa, 2016). With the technique of member checking being employed to establish credibility, what is concluded, the

interpretations, and the data will be shared with the participants (Amankwaa, 2016). As this is a vulnerable population, IRB guidelines will be followed.

Chapter 2: Literature Review

Introduction

There is a pressing need to enhance the availability and quality of mental health services provided to persons from historically disadvantaged racial and ethnic groups (Kulis et al., 2015). Several previous research studies have recommended that conventional mental health treatments need to be altered to accommodate patients that come from different cultural backgrounds (Cramer & Olivo, 2016; Kulis et al., 2015; & Parra Cardona et al., 2017). Researchers have discussed adapted interventions (Freyer-Adam et al., 2019; Hense et al., 2018; Pfefferbaum et al.,2017), and in this study, I provided an overview of the necessity of culturally adapted interventions for young adult Latina women who are experiencing mental health problems. This review will summarize the past and current literature on culturally adapted interventions that address mental health issues to allow for a concise account of the current state of knowledge in this area, limitations, and guidance for the future research.

Approach to Literature Search

I conducted a literature search using the Walden University database and Google Scholar. I reviewed the abstracts of several peer-reviewed psychology journals. I used the keywords culture*, Latino,* and *intervention*. This first mixture of keywords yielded 567 peer-reviewed journals that ranged in years between 2012 and 2019. Abstracts of the peer-reviewed journals that were reviewed were used to find current research studies on cultural competence, interventions, and mental health issues involving Latinos.

PsycArticles and EBSCOHost databases were also examined to reveal and assess supplemental journals related to Latinas and cultural interventions.

The following subjects will be discussed in this chapter: the diversity of Latinos, the relationship between identity and culture to mental health, barriers to mental healthcare, cultural competence in healthcare, the prevalence of mental health issues in the Latino community, and Latina women and their adverse experiences.

Summarization of the Present Literature

As noted in several research studies over the years, many healthcare professionals have gradually acknowledged the need to enhance the cultural competence of services and cultural adaptation of interventions so that every individual can benefit from evidence-based care (Cramer & Castro-Olivo, 2016; Dillon et al., 2018; Freyer-Adam et al., 2019. There have been several attempts at culturally adapting evidence-based interventions for mental health problems; however, there has still been much debate on this subject (Freyer-Adam et al., 2019; Li, 2016). Additionally, where Latinos are concerned, there remains an absence of a comprehensive review of meta-analysis and literature reviews that guide policymakers and healthcare professionals (Bruzelius & Baum, 2019; Parra Cardona et al., 2012).

Many of the current research studies are overwhelmed with focus mainly set on white participants. Generalizability complications can arise when attempts are made to apply these methods to culturally diverse populations (Bakhshaie et al, 2018; Barragán et al., 2019; Dillon et al., 2018**).** The literature committed to cultural competency, in mental healthcare, for Latin Americans is insufficient.(Gardner & Kerridge, 2019). The objective

is to increase the current literature on culturally tailored interventions. Mental health details for Latinos will be the focus.. Specifically, perceptions of current mental healthcare initiatives about cultural identification will be explored. The impact on Latinos' motivation when seeking and utilizing mental health supports will be discussed. In this study, my goal was to contribute to the ongoing literature by discussing the evidence-based practices that could be used to assist Latin Americans with quality healthcare and the reduction of mental health issues.

Latino Population

The Latino community is a remarkably diverse group of people who are usually set apart by their country of origin. For this group, mental health is usually a stigmatized topic which causes them to continuously endure mental illnesses such as depression and anxiety in silence (Dillon et al., 2018). The CDC estimated that by 2060, the Latino population will have increased to 119 million people, or over 28% of the United States population (CDC, 2020). Sixty-two percent of U.S. Latino people have a Mexican background, followed by 9.5% with a Puerto Rican background, 3.9 % with a Salvadoran background, 3.9 % with a Cuban background, 3.5 % with a Dominican background, and 2.5 %with a Guatemalan background (CDC, 2020). Latinos make up 33% of the United States immigrants, 19% are destitute, and 79% of these Latinos who reside in the United States are citizens (CDC, 2020).

Several research studies have shown a correlation between acculturation and Latinos' vulnerability to mental illness (Dillon et al., 2018; Fedina et al., 2020; & Mata-Greve & Torres, 2018). At-risk groups like Latinos experience unbalanced substandard

health results because of disparities such as quality of healthcare services and accessibility of health insurance coverage (Dillon et al., 2019). Cultural differences are prevalent. With globalization making numerous countries culturally diverse, a responsibility is placed upon healthcare systems to ensure that services are culturally relevant to the populations they will potentially provide services to (Cramer & Olivo, 2016; Kulis et al., 2015). Proactive measures will assist in decreasing health disparities through cultural responsiveness, appropriateness, and effectiveness of healthcare services (Fendt-Newlin et al., 2020). Lack of cultural competence and cultural adaptations in systems of care is a leading cause of disparity in services for Latino cultures leading to reduced or no utilization of available services, adverse outcomes, and increasing the cost to society (Parra Cardona et al. 2017; Rhodes et al., 2015; Schwartz et al., 2017). Therefore, the generalization of findings on the effectiveness of mental health interventions for Latinos may not be valid or appropriate (Fuentes et al, 2018).

Despite the potential for cultural inconsistencies to render treatments ineffective, healthcare professionals and researchers are disseminating interventions locally and globally across widely diverse cultures; the expectation being these efforts gradually improve this gap (Parra Cardona et al., 2012). To date, no comprehensive review of meta-analyses is available with a detailed summary of findings, guidance on the state of current evidence, and directions for future practice (Sheehan et al., 2016; Suárez-Orozco et al., 2015).

Due to the lack of literature on this specific population, this study intended to focus on cultural competency and mental health issues among Latin Americans (Dow et

al., 2018). My objective with this proposed study is to increase the current literature on culturally tailored interventions. By broadening the prevailing literature with Latino mental health details, I will seek to contribute to the existing literature. This will involve outlooks regarding current mental healthcare initiatives about cultural identification. Outlooks of Latinos could have an impact on their motivation when using mental health supports.at With this qualitative research study I will potentially contribute to the existing literature by informing on the evidence-based practices that could assist in reducing disparities in mental health. Dow et al., (2018) notes, this could help with increasing quality mental healthcare for Latino Americans.

Latinos and Health Disparities

Health disparities are defined as the differences in mortality, prevalence, and incidence of a medical condition and the related adverse health conditions that exist among specific population groups are health disparities (CDC, 2020). Specifically, the identification of these groups can include race, age, gender, and ethnicity (CDC, 2020). Health disparities are among the reasons why medical conditions such as depression or chronic conditions such as heart disease and diabetes can affect some groups at a higher rate than others (CDC, 2020). For example, White Americans are more likely than Latino Americans to have insurance coverage (Dillon et al., 2019). This means that White Americans face fewer challenges or barriers to receiving services.

Over the last few decades, psychologists and other health professionals have called attention to the importance of considering cultural and ethnic aspects in any psychosocial interventions (Dillon et al., 2019). Although at present there are published

guidelines on the practice of culturally competent psychology, there is still a lack of practical information about how to carry out appropriate interventions with specific populations such as Latinos (Barragán et al., 2019; Ramos-Sánchez, 2020). Latinos experience many of the same behavioral health disorders as other ethnic and cultural groups in the United States but underutilize healthcare services relative to many other groups (Fendt-Newlin et al., 2020; Li, 2016). This underutilization may be related to issues such as acculturation level, stigma, and language, all of which have the potential to create barriers to receiving treatment (Li, 2016).

Freyer-Adam et al (2019) notes, a comprehensive review of the literature demonstrates a repeated hesitancy within the field to define and commit to a specific theoretical framework even though intervention practice has generally gained sufficient acceptance among mental health professionals as a valid practice approach. (Freyer-Ad. One of the significant gaps in the literature is a discussion of cultural differences specifically of young adult Latina women, and how these may impact their responses to stressful events, dynamics of the patient/doctor relationship, and the implications for successful resolution of adverse experiences (Fendt-Newlin et al., 2020; Parra Cardona et al., 2012).

Latinos and Mental Health Issues

Historically, Latinos have been less likely than white people to seek out, use, and retain mental health services (Flynn et al., 2015; Kaltman et al., 2016). Studies have shown that as time passes, the Latino population in the United States will only increase in size and if the mental health disparities faced by Latinos continue to be insufficiently

addressed and misunderstood, their mental health needs will go unfulfilled and they will continue to suffer unfairly (Labash & Swartz, 2021; Eghaneyan et al.,2017; Lara-Cinisomo et al., 2021).

An analysis of the data related to mental health issues involving Latinos revealed that minimal access to healthcare combined with a high vulnerability to mental health issues places the Latin population at risk of experiencing critical mental health problems (Kaltman et al., 2016; Pineros-Leano et al., 2021; Velez et al., 2015). Traditionally Latinos have had less access to screenings, diagnoses, and treatment of mental health problems than White Americans (Costantino et al., 2009; Villatoro et al.,, 2016). Latinos also experience unreasonably higher mental health needs because of their lack of access to healthcare and they may not be aware of their conditions, which may cause these mental health issues to go untreated (Villatoro et al., 2016). According to Costantino et al (2009), it is more common for Latinos to be affected by mental disorders and are diagnosed with more than one mental issue as compared to non-Latino whites (Costantino et al., 2009). Villatoro et al (2016) discussed, mental disorders have not only been known to reveal impediments to a person's wellbeing and functioning, but they can also increase the risk of disability. Mental health issues are distressing and have the potential to be exceptionally overwhelming for Latinos when their needs for mental healthcare are unmet due to their underutilization of mental healthcare services and the healthcare that they receive is insufficient (Villatoro et al., 2016).

The research from Kaltman et al., 2016; Pineros-Leano et al., 2021;; Velez et al., 2015 revealed that researchers have analyzed mental health issues and stressors

associated with Latinos. It was determined that Latinos experienced further stressors specific to the environments they live and work in. Researchers suggested Latinos experience acculturative stress because of the pressures that correspond with incorporating into a new culture (Villatoro et al., 2016). Researchers found this stress was more likely brought on by the anxiety of leaving family members behind in their native country and being alone as well as feeling isolated in their new country (Kaltman et al., 2016; Pineros-Leano et al., 2021; Velez et al., 2015). Feeling deprived of a social support system or family can disturb an individual's mental health (Costantino et al., 2009). Becoming newly associated with a different culture may cause Latinos to experience mental health issues because of the stress placed upon them due to contention with the more influential culture (Costantino et al., 2009).

In reviewing the literature related to Latinos and mental healthcare, it was noted that the cost of healthcare services, language, and insufficient transportation, are factors in the mental health disparities Latinos face (Bridges et al., 2014; Costantino et al., 2009; Villatoro et al., 2016). The literature has shown mental healthcare providers who seek to provide effective quality healthcare to Latinos and keep them engaged in treatments believe a comprehensive approach that incorporates the patients' spoken language, culture, and values is a more substantial path to healthy results (Cordero et al., 2006; & Flynn et al., 2020).

Mental stress such as anxiety and depression can be experienced by Latinos who leave their collectivistic familial backgrounds behind to settle in a new country where they are now made to feel marginalized (Dillon et al., 2019). Amending familiar practices

and replacing cultural values can bring on mental stress when having adverse experiences with a new country's institutions such as schools and the workforce (Dillon et al., 2019). Research has shown that within the Latino population, men are less likely to seek out mental healthcare (Velez et al., 2015). Latino men are said to be more opposed to mental health treatments than Latina women because they are heavily grounded in the masculine traditions of their culture and the stigma that follows men and their stamina (Velez et al., 2015). Latina women, however, are more likely to use health care services, particularly when they are in the need of gynecological services (Dillon et al., 2019). Young adult Latina women experience high rates of depressive symptoms, stress, and anxiety which are caused by stressors such as domestic violence, teen pregnancy, separation from children and family, and persecution (Kaltman et al., 2016; Velez et al., 2015).

Young Adult Latina Women and Mental Health

Researchers have shown countless immigrants come to the United States with aspirations and expectations of a better life; however, the migration, and acculturation, along with leaving behind family supports and traditions, have placed young adult Latina women in a vulnerable position which may have left them prone to mental health issues (Kaltman et al., 2016; Valdez et al., 2018: Velez et al., 2015). Among Latina women, depression is common, and mental health services for young adult Latina women are one of the least represented ethnic groups (Valdez et al., 2018). Studies have shown that young adult Latina women have minimal access to social support systems, and they are often met with difficulties when developing new trusting relationships as they adjust to

being in a new country (Kaltman et al., 2016; Valdez et al., 2018; & Velez et al., 2015). Studies demonstrate when analyzing data for differences in marital status, education, and employment, rates of depression are higher among young adult Latina women than white and black women (Kaltman et al., 2016; Valdez et al., 2018; & Velez et al., 2015).

For young adult Latina women, policies that affect mental healthcare are essential because they experience barriers to accessing support and quality healthcare, particularly in the areas of prenatal care, sex education, preventative care, pregnancy, domestic violence, housing, employment, and mental healthcare; most of which have a negative relationship with mental wellbeing (Valdez et al., 2018). Interpersonal relationships provide a means of social support, social influence, social engagement, and interpersonal contact, all of which have a significant impact on an individual's physical and mental health (Alvarez & Fedock, 2018; Ruiz et al., 2013; Urizar et al., 2019). Social support has been established as a significant factor in a person's physical and mental well-being (Urizar et al., 2019). When young adult Latina women feel isolated and cut off from these social supports, this can have the exact opposite effect on their mental well-being (Urizar et al., 2019). Young adult Latina women living in the United States, who have left behind significant relationships in their home countries, often get faced with unmet expectations from new family and friends leaving them feeling isolated and not having the familiar experiences they left behind (Ruiz et al., 2013).

Poor mental health that may be stemming from domestic violence or other traumatic experiences complicates matters when trying to overcome barriers (Labash & Swartz, 2021; Pineros-Leano et al., 2021). Young adult Latina women who experience

domestic violence are placed at a greater risk for posttraumatic stress disorder (PTSD), and other long-term health issues and disparities (Labash & Swartz, 2021; Pineros-Leano et al., 2021). Regarding young adult Latina women, the impact of the exposure to violence and trauma requires more research detailing the implications of these experiences to assist this population with their mental well-being (Labash & Swartz, 2021; Pineros-Leano et al., 2021).

My literature reviewed notes that young adult Latina women who have had exposure to traumatic experiences are more likely to meet the criteria for a mental disorder and have a higher prevalence of being diagnosed with multiple mental health disorders (Pineros-Leano et al., 2021). Studies also reveal most young adult Latina women acknowledge and can identify depression; however, in the first instance, do not associate it with an illness that requires specific medical attention (Labash & Swartz, 2021; Pineros-Leano et al., 2021). It is believed that what they are experiencing is due to personal or cultural factors that stem from circumstances with their family, finances, or education (Labash & Swartz, 2021; Pineros-Leano et al., 2021). Researchers believe these same social and cultural factors influence the healthcare preferences of this population, which largely tends to rely more on social interventions than prescribed medications (Eghaneyan et al., 2017; Lara-Cinisomo et al., 2021). Comprehensively addressing the health care preferences of young adult Latina women is an essential component of the efforts in providing them with quality mental healthcare (Eghaneyan et al., 2017; Lara-Cinisomo et al., 2021).

Researchers must continue to address the barriers young adult Latina women encounter when seeking support for mental health conditions like anxiety and depression (Eghaneyan et al., 2017). Most of the research done on depression has been conducted on white populations which creates limitations for healthcare providers who are seeking to address the needs of patients who are socioeconomically disadvantaged like many young adult Latina women, who are disproportionately impacted by high rates of depression (Valdez et al., 2013). It is essential to the mental well-being of young adult Latina women that practitioners and researchers understand the relationship between this population and mental health disorders such as depression and anxiety when they are interested in creating culturally appropriate interventions for this vulnerable population (Eghaneyan et al., 2017; Valdez et al., 2013). Research spanning over 20 years shows that young adult Latina women with depression and anxiety disorders have a higher rate of developing social impairments and mental health problems, as well as physical disabilities that persist well into their adulthood when these problems are not given the proper treatment (Valdez et al., 2013).

Young adult Latina women encounter significant mental health disparities related to the quality of care, access to care, and the outcomes they receive (Eghaneyan et al., 2017; Kaltman et al., 2016; Valdez et al., 2013). Studies also show persistent health disparities are experienced throughout the lives of these women, and in addition to lacking access to quality mental healthcare, they are less likely to have a regular source of healthcare than black or white women (Kaltman et al., 2016; Urizar et al., 2019). Continuity of mental healthcare, having an ongoing patient/professional relationship that

is based on trust and responsibility, significantly increases the use of specific healthcare services (Flynn et al., 2015; Kaltman et al., 2016; Ruiz et al., 2013; Urizar et al., 2019). Recent research studies have revealed that young adult Latina women's perceptions of healthcare mistreatment such as lack of respect, poor communication, and unprofessional conduct on behalf of the healthcare professional hurt retaining mental healthcare services (Flynn et al., 2015; Kaltman et al., 2016).

The literature reviewed suggests that the negative experience of young adult Latina women and mental healthcare professionals may influence the probability that the women from this group will stop utilizing mental healthcare services (Flynn et al., 2015; Kaltman et al., 2016). Understanding the emotional perceptions of young Adult Latina women and how they perceive the way they are mistreated while receiving mental healthcare services may assist healthcare professionals with improving office visits, patient/doctor relations, continuity of care, and health outcomes for this specific population (Flynn et al., 2015; Kaltman et al., 2016).

Cultural Identity Versus Cultural Competence

The United States is an ethnically diverse society, and the diversity will continue to increase as more immigrants arrive from other countries (Weaver & Wodarski,1995). It is not uncommon for human service practitioners and their clients to have different cultural backgrounds. The difference, however, has the potential to limit the effectiveness of services (Biggs et al., 2013; Weaver & Wodarski, 1995). Although organizations such as the Council on Social Work Education, the American Psychological Association, and the National Association of Social Workers have expressed concern about racism and

cultural insensitivity within the healthcare profession, dating back to the 1990s, Weaver and Wodarski (1995) found that healthcare with Latinos appears to be of marginal interest for the profession and that the literature on young adult Latinas is superficial, and fails to address their adverse social factors.

Therefore, it is likely that most human service professionals are not providing culturally competent services. A culturally unaware healthcare professional worker or other human services professional is likely to provide services based on his or her cultural outlook (Cramer & Castro-Olivo, 2016; Weaver & Wodarski, 1995). This is particularly difficult because providing biased and culturally inappropriate services and imposition of the worker's values can lead to further oppression of a patient's vulnerability (Weaver & Wodarski, 1995).

If a human service professional fails to recognize this diversity and does not assess the meaning of culture for the client, the provision of services is likely to be based on stereotypes and inappropriate assumptions rather than actual cultural variables (Weaver & Wodarski, 1995). Culture and ethnicity have a significant influence on how individuals think, feel, and behave (Fuentes et al., 2018). This is also true for healthcare professionals as well as for people in need of help (Fuentes et al., 2018; Weaver & Wodarski, 1995). Norms and behaviors into which people are socialized vary according to cultural conditions (Kliewer et al., 2016). Culture certainly affects what individuals identify as a problem, beliefs about the origin of a problem, how to resolve it, and which types of individuals they believe are appropriate to assist in helping to resolve the

problem (Kliewer et al., 2016; Kulis et al., 2015). Culture also has implications for how people respond in times of adversity (Kulis et al., 2015).

Challenges in Patient /Doctor Relationship

When clients and human service professionals are from different cultural backgrounds, it can be difficult for them to understand each other and form a productive working relationship (Li, 2016). These challenges may be particularly apparent when both the patient and health care professional become caught up in the resolution of the issue; however, the client-doctor relationship must be a safe place in which the cultural differences between client and doctor are bridged (Weaver & Wodarski, 1995). In this respect, culturally diverse healthcare practices are a natural projection of some of the basic principles of quality healthcare practice; it differs in the effort that must be expanded to understand a different worldview and to ensure that the practitioner does not impose his or her world view (Weaver & Wodarski, 1995). To accomplish this, the human service professional is faced with the following three challenges: understanding the client's culture and worldview; recognizing his or her worldview and biases and the effects these have on the relationship; recognizing the influence of institutional biases such as educational systems of healthcare workers and interventions used in the helping process (Weaver & Wodarski, 1995).

Many health care professionals may not even be aware of the difficulties that exist (Li, 2016). Communication is more consistent when the healthcare professional and the client have similar world views (Kliewer et al., 2016; Kulis et al., 2015). Healthcare professionals should approach the relationship with an openness to learning about the

client's perception of the problem, its causes, and potential solutions (Kliewer et al., 2016; Kulis et al., 2015; Weaver & Wodarski, 1995).

Conflict and Resolution

A lack of understanding of cultural differences may lead to conflict and misinterpretation when healthcare professionals are treating clients (Li, 2016). For instance, different cultures have different definitions of success. In the dominant culture, someone who climbs the corporate ladder, receives job promotions, and earns a large salary is considered successful (Ordonez, 2016). In many Latino cultures, a person is considered a success if people seek him or her out for advice and wisdom (Ordonez, 2016). Interdependence among people is valued in many Latino cultures (Parra-Cardona et al., 2017). Therefore, concepts such as codependency must be reevaluated for relevance within cultural contexts before something valued by one culture is labeled extreme according to dominant society standards (Weaver & Wodarski, 1995). Cultures vary according to individualistic or group orientations (Quinones-Gonzalez, 2013). According to Weaver and Wodarski (1995), the common mistake healthcare professionals make in providing mental health services to culturally diverse individuals is in generalizing them and assuming that these individuals are the same as others from different cultural backgrounds.

Therefore, mental health interventions and other forms of counseling should be directed primarily toward individuals rather than groups, families, societies, or organizations (Weaver & Wodarski, 1995). Although many health care professionals are trained to look at a client's situation from a social system or ecosystem perspective, the

emphasis is usually on the here and now and in some cases, historical factors are relevant to a client's trauma (Rhodes et al., 2015). Latino patients who believe that an adverse experience has occurred because it was their destiny may have difficulty understanding a social worker who tries to get them to take charge of their lives (Ordóñez, 2016). Practitioners providing mental health services often inappropriately assume that cause and effect straightforward thinking is appropriate for explaining how the world works; however, the Latino culture has a more circular world view in which a variety of factors are perceived to influence an outcome (Ortiz Juarez-Paz, 2017).

Patterns of communication vary across cultures (Li, 2016). There are cultural differences in the norms and expectations concerning verbal, emotional, and behavioral expressiveness, insight, and expectations about discussing personal information (Li, 2016). Professionals may expect clients to be willing to discuss their problems; however, this professional norm may be contrary to the norm of the client's culture (Li, 2016). For example, many Latinos consider it shameful to openly discuss problems (Ordóñez, 2016). Another common bias often held by professionals providing mental health intervention services is the belief that formal counseling is better than help given through natural support networks. Many issues are resolved through these support networks before they are brought to social agencies (Ordóñez, 2016).

Summary

The chapter I just completed provided a review of the subjects related to the qualitative research study. In this chapter I reviewed the different elements that hurt the mental health of young adult Latina women including depression and anxiety. Cultural

competence in healthcare and the diversity of Latinos were discussed. The prevalence of mental health issues in the Latino community, Latina women and their adverse experiences, and barriers to mental healthcare were also examined. My review of the literature demonstrated that details were relevant to the adverse experiences of young adult Latina women such as language barriers, accessibility to healthcare, obstacles to employment, and adjusting to living in the United States of America.

The literature I reviewed revealed a gap between young adult Latina women and the use of culturally specific interventions to provide support for their mental healthcare. Culturally adapted interventions are critical to the psychological care of young adult Latina women. Healthcare providers must integrate their traditional mental health care practices with culturally specific mental healthcare strategies that address the cultural values and roles of young adult Latina women. This vulnerable group should instead be empowered with tools to assist them in seeking out and engaging in quality mental healthcare. My research study served the purpose of answering the question: What role do culturally specific interventions play in healthcare initiatives used to address the mental health issues experienced by young adult Latina women? The following chapter will explain the research methods and design that were used to answer this research question.

Chapter 3: Research Method

Introduction

With this chapter I will identify, outline, and defend the sampling, recruitment, contribution, and data collection strategy for this research study. I will also establish and support the tools used in the research study and outline the data analysis approach, and the prospective threats to validity. Finally, the chapter will finish with the ethical policies and procedures for this research study.

Proposed Research Design

A qualitative research approach can be used in different disciplines such as public opinion polls and policy research (Marchel, 2004). The qualitative research design involves assembling written data, analyzing data to identify themes, and describing the experiences of the participants (Carter & Little, 2007; Denzin & Ryan, 2007). In qualitative approaches, causality is not assessed, and interview questions are open-ended (Carter & Little, 2007; Denzin & Ryan, 2007). Qualitative researchers explore the meaning individuals or groups attribute to social and/or personal issues in their lives (Marchel, 2004). The qualitative research approach entails an examination of inductive and deductive data from participant interviews to identify patterns and themes (Carter & Little, 2007; Denzin & Ryan, 2007; Flick, 2014). What sets the qualitative research approach apart from other methods is the adaptability of the research design that starts with creating a research question (Flick, 2014; Marchel, 2004). For the present research study, I will use qualitative approaches to understand how culturally specific interventions can provide support to young adult Latina women. Freyer-Adam et al.,

2019 discusses with mental stress or depression that may be brought upon by pressures. This may include employment, education, housing, and healthcare. With this study will specifically analyze how culture plays a significant role in an individual's life making it a necessity for healthcare initiatives to be culturally adaptable (Parra Cardona et al., 2017).

Because the cultural aspect of the chosen sample's lives is a significant part of the research study, I reviewed the ethnographic approach as a possible tool for the study It was not chosen. Levitt (2020) wrote it requires extensive participant observation which will not be necessary for this study. It is not necessary for me to be immersed in the culture of the participants to retrieve the data that is needed. I will require control over what data is needed; therefore, an ethnographic approach was decided against. Levitt, 2020 noted it also has the potential for continuous observation with no ending to what is being observed. I considered the case study approach. Hollweck, 2015 noted this approach does not place attention on themes shared by the subjects being observed. Emphasis is more so placed on an in-depth description of a group, process, or activity over a significant amount of time.

Using a qualitative phenomenological research method is pertinent to this study. I gathered several participants who will potentially report common definitions or understanding of lived experiences. Knudson, 2015; Li, 2016 notes their experiences with accessing, using, and continuing with competent healthcare services provides the needed link. Knudson, 2015 discussed phenomenological studies can be divided among different types of experiences such as memory, emotion, perception, and thought. Knudson, 2015 also noted the phenomenological approach is distinctive because it begins with a

phenomenon that is being explored not with a theory. The focal point can be altered depending on whether it is a genuine account or a knowledgeable explanation. The reasoning behind using a phenomenological approach in the present study was I want to recognize that the participant's result is not simplistic or without depth but is a mixture of all her experiences. To achieve a rigorous analysis of each participant, I will use a particular approach. I chose a sample size of 12 ton15. Robinson, 2014 noted with the interpretive phenomenological analysis (IPA) approach, a sample size of 12 to 15 will leave room for any recruitment challenges such as the sensitivity of the topic. Gaining access to potential participants and participants who do not have access to devices needed to conduct virtual interviews could create a challenge in recruiting. Denzin & Ryan, 2007; Roy et al., 2015 note challenges like I mentioned have the potential to undermine the validity of the study (

Research Question

The purpose of this qualitative phenomenological study was to investigate and acknowledge the lived experiences of young adult Latina women dealing with mental health issues and the impact of culture on the experiences. The goal was to demonstrate the need for culturally specific interventions to support mental health issues in different populations and make suggestions for subsequent application of mental health supports to assist young adult Latina women. The research question was: What role do culturally specific interventions play in healthcare initiatives used to address mental health issues experienced by young adult Latina women?

Sampling Participants

The population I selected for this study was young adult Latina women who help to make up the increasing twenty-nine-point one percent of the Latino population in New York City (CDC, 2020). The women I selected were legal residents between the ages of 18 and 35 with or without a high school diploma or higher degree. They must reside within one of the five boroughs in New York City (Queens, Manhattan, The Bronx, Brooklyn, or Staten Island). The participants must speak English and be receiving or actively seeking mental health care resources.

I selected this age group because young adult Latina women have a belief in the fundamentals of living the American dream. They want equal opportunities and to achieve high goals and aspirations for themselves and their children. They are striving to achieve these goals, Parra Cardona et al., 2017 notes mental health issues are on the rise for this group. As contributors to American society, they should have access to the same healthcare resources as everyone else who contributes to American society. I recruited the samples for this study from the New York City Human Resources Administration Department of Human Services.

Procedures for Sampling and Sample Size

A significant element of the qualitative research design is sampling (Robinson, 2014). Sampling is not an option based solely on the sample size, it also involves the cohesion and trustworthiness of the research study's purpose, framework, and depth of data (Roy et al., 2015). Purposive sampling helps reflexive researchers to develop and test theories about the social world (Collins, 2010; Emmel, 2013). To ensure that there is

enough data to support my study I selected a sample size of 15. Sheehan et al. (2016 in a phenomenological study the sample range can be from six to 10 participants. I selected 15 to leave room for any unexpected recruitment challenges. With the planning and execution of the research, I made clear my understanding of the nature and essence of the social world (Collins, 2010; Emmel, 2013).. I discussed what evidence or knowledge is needed to know a social phenomenon, and the audience I wanted to address with a particular social problem.

Furthermore, in using purposive sampling, researchers do more than act reflectively. Through engaging in deep and careful thought, they are also reflexive (Collins, 2010; Emmel, 2013). They recognize the presence of the researcher in what is being investigated and they actively shape their research in the social world, including making ongoing decisions about sampling in their research (Collins, 2010). Collins, 2010; Emmel, 2013 noted the purposive sampling strategy develops and tests theoretical arguments through strategic sampling strategies chosen to get at what it is the researcher wants to know about a phenomenon that is specified as the research progresses. The validity of the research requires the researcher to retrace and reconstruct the route through which claims are made and this includes understanding and explaining the sampling done in the research (Collins, 2010; Emmel, 2013). The key to purposive sampling is recognizing that a phenomenon will be revised throughout the research and research is a process of identifying the conditions under which causal relations operate and then revising explanations based on the investigation of the evidence (Collins, 2010; Emmel, 2013). As discussed in Robinson, 2014 the sample range I selected provided

latitude for creating cross-case analysis and established enough data to support the research study.

Participant Recruitment

The purpose of this research study was to examine the need for culturally specific interventions in providing mental health support to young adult Latina women between the ages of 18 and 35. I chose The New York City Human Resources Administration Department of Human Services as the agency where the participants were recruited. This is a government agency where a vastly diverse groups of people frequent for the services it provides. To achieve purposeful sampling Robinson (2014), the location was the basis for the location I selected.

Due to the current state of emergency that New York City is in, because of the ongoing COVID-19 pandemic, there was limited staff allowed into the work locations. I obtained written approval (Appendix A) from the agency Director to solicit participants from the agency. I chose participants who were receiving services from the New York City programs, and who were included in the limited population allowed in the work locations daily. I scheduled an appointment to enter the work location. Upon my access, I was allowed to place a flyer on each of the five floors that received clients explaining the research study and soliciting individuals to take part in the study on culturally specific interventions and their relation to young adult Latina women and quality mental healthcare.

I conducted the interviews via video conference (Zoom), and I noted in the flyers that access to devices such as laptops or phones will be needed to take part in the study.

My recruitment flyer (Appendix B) described the research study and provided my secondary contact information. I asked anyone who was interested in taking part in the study to correspond with me using the details given in the flyer. Once I was contacted by the intended participants a time was scheduled with them for the video interview. Consent forms were signed electronically using email, and background information was gathered on each participant. I then conducted semi structured interviews in which I asked open-ended questions to gain the most data from each participant on their interpretation of their experiences.

The Role of the Researcher

The interview process of a qualitative research study can be extremely emotional for both the researcher and the participant (Cumyn et al., 2018). With the weight of the ethical conduct resting solely with the researcher, it is imperative to the trustworthiness of the study Cumyn, et al., (2018), that I, as the researcher understand my role, and their role is understood as well. The participants and I could have an impersonal work relationship. The data collected could be impacted by this acquaintance due to my surface knowledge of some of the adverse experiences these young adult Latina women have had. To avoid the possibility of bias Postholm & Skrøvset (2013), I employed the research tool of reflexivity. This will assist me with being aware of my assumptions and prejudices. Reflexivity allowed me to view myself introspectively and correct my thoughts and actions. Once the interview process began, I also kept a journal so I could return to what I observed and reflect on my thoughts on the actions of the participants and myself.

Instrument

For the instrument to be considered credible, results should be similar when replicated using the same methodology (Bourne & Robinson, 2015). For this study, I used semistructured interviews as the primary means of gathering information. Interviews are the primary method of data collection in a phenomenological study (Bourne & Robinson, 2015). My interviews allowed me to explore, illuminate, and probe the participant's description of the phenomena and reflect on the data provided. The role of the interviewer involves getting the participants to relax enough to engage in a free exchange of dialogue (Taylor & DeVault, 2015). Taylor & DeVault (2015) noted this is achieved by in-depth qualitative interviewing, also called face-to-face encounters, between the researcher and participant, directed toward understanding the participant's perspectives on their lives, experiences, and situations as expressed in their own words . My goal was to gain an understanding of the lived experiences of other people and the meaning they made of those experiences

Durdella (2019) noted the semi structured interview offers, by inviting an exchange of dialogue between the interviewer and interviewee, engagement (Durdella, 2019; Husband, 2020). With this engagement, the researcher is actively constructing knowledge along with the participant, constructing answers to questions that may require them to consider issues in a depth that was not realized in a previous exchange (Durdella, 2019; Husband, 2020). Husband (2020) discussed the engagement between researcher and participant offers the potential for critical reflection on concepts, ideas, and opinions that may be formed as the answers are constructed or newly expressed as they are

recalled. The research interview can be developmental for both the researcher and the participant (Husband, 2020). As ideas are shared and expressed, the understanding of experiences and development of new knowledge offers the opportunity for a formative experience for both researcher and participant (Husband, 2020). I created the semi structured interview guide, (Appendix C). Durdella (2019) notes the interview guide will assist with collecting in-depth data on the experiences of the participants to help with answering the research question . When noting the results of the analysis, I referenced the participants by P1 through P12. I used three instruments, to gather data. This was discussed in the data collection section of this chapter.

Data Collection

For this phenomenological study, I chose semi structured interviews for the data collection method to explore the lived experiences of young adult Latino women, as it relates to mental healthcare and culturally specific interventions. My exploration of the lived experience is the primary intention of the study. I held semi structured interviews that were later transcribed. In a phenomenological interview, the researcher is studying a participant who provides accounts of their world, themselves, and their perception regarding experiences to bring about knowledge (Bourne & Robinson, 2015). Bourne & Robinson (2015) noted in-depth interviews allow for firsthand and direct knowledge about the individual being interviewed. The face-to-face interviews I performed provided unspoken knowledge which was found in the participants' body language, tone usage, and facial expressions, which otherwise could not have been obtained. In addition to conducting interviews, I kept field notes. Campbell et al (2020) discussed field notes help

interpret the context of the interview which is vital during data analysis. Field notes I took allowed annotations of impressions, nonverbal cues, behaviors, and environmental context not otherwise captured through audiotapes. I also kept a reflexivity journal throughout the research. Reflexivity journaling was discussed earlier when I addressed trustworthiness in this chapter.

Data Analysis

Remaining true to the participant is the most critical part of data analysis in a qualitative study (Engle, 2015). I used the data analysis approach of Engle (2015). Engle (2015) discussed researchers should transcribe, check, read between the lines, code, theme, and synthesize data. As Engle (2015) noted transcription will be completed so that spoken words are converted to written words that can be analyzed. The coding I did helped me to identify similarities regarding topics and issues revealed through the narratives of the participans. Engle (2015) notes when coding a researcher searches for and identifies ideas and looks for a link between the ideas.

Qualitative data analysis is time-consuming, involved, and detailed. It involves steps that generally include processing and transcribing data, storing data files, segmenting, coding transcribed data, identifying themed patterns, and developing theorized storylines (Durdella, 2019). While an overall thematic structure to data usually happens as a culminating activity near the end of an investigation, data analysis as a process occurs throughout a study. This leads to patterns that can be shared with other researchers, practitioners, and policy makers (Durdella, 2019). For me to gain a better understanding of the perspectives held by young adult Latina women on their adverse

experiences involving seeking and engaging with mental health supports, I chose a qualitative analytic process. The qualitative approach I chose also helped me to analyze how culturally specific interventions can help provide them with quality healthcare. The data I collected was examined through this analytic process. My goal of pattern-producing activity in my qualitative research study was to be able to say something and contribute to discussions about the topic. I also wanted to help shape how we think or what we do about the phenomenon under investigation. Durdella (2019) noted in qualitative research, the outcome looks very much like a story.

Data analysis moves from unassembled sources of complete data, such as transcribed interview files and written field notes, to segmented and coded data organized into meaningful groups, to data reassembled from the original forms as larger thematic patterns (Durdella, 2019). In doing so, you apply a research framework that has informed your entire investigation, and you also bring a sense of order to what would otherwise be an unbalanced and unorganized combination of texts (Patton, 2014). In the end, the analytical process in qualitative research is what Patton (2014) explains as transforming data. This explanation hinges on the key term: transform. The force of a researcher's work in data analysis is on working with multiple sources of information and making sense of what you hear and see in the field, ultimately relating what people share in one context to what people understand in another (Patton, 2014).

Trustworthiness Strategies

For me to ensure trustworthiness in the qualitative findings, I utilized two strategies, reflexivity, and triangulation. Campbell et al (2020) noted triangulation is the

use of various sources for data collection to draw a comprehensive conclusion and perception of the phenomena. Data collection methods included 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 (Campbell et al., 2020).

To ensure that I remained objective, I kept a reflexivity journal. My reflective journal will help identify personal biases, personal beliefs, and any other external personal factors that may have influenced my research findings. According to Campbell et al., (2020), to certify credibility and conformability, triangulation can assert validity as it involves utilizing two related sources of data or methods of collection to reduce ingrained bias.

Ethical and Protective Measures

For me to ensure compliance with ethical and legal codes, Walden University's Institutional Review Board (IRB) was applied for approval to execute this qualitative study. I did not attempt to contact individuals, agencies, or organizations before approval. No conflict of interest existed for this study. Every participant was required to sign a consent form. I found individuals suitable for this study who were Latino women between the ages of 18 and 35. My research involved potentially sensitive topics such as mental health and family dynamics. Stress and potential emotional discomfort could occur in this study; there was no known harm linked with this research. I informed every participant was that they were allowed to stop their participation in the study at any time

there was discomfort and without penalty. Everyone was provided with a referral list of community mental health services at the end of the interview (Appendix D).

Confidentiality

I made provisions to ensure confidentiality. Before I gathered information, as mentioned, I obtained permission from the IRB. Once I received permission, the research process began. Each participant I selected was required to sign a consent form using the electronic resource being emails. I provided an invitation to participate to all the individuals who met the requirements for participation. My 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. I informed all the participants they were required to sign a consent form before the interviews.

For me to further ensure confidentiality, I concealed all identifiable information. Personal identifiers, locations, and organizations were not used. I assigned each participant an identification number to maintain adequate information. I only allowed consent forms to contain the real names, demographic and contact information. I have stored the Consent forms securely in a locked file cabinet in my residence. Only I have access to the residence and the file cabinet keys.

Summary

I outlined how the study was conducted in this chapter. I included a synopsis of how I implemented a phenomenological design and research methods used to explore the lived experiences of Latina women, 18-35. I also included the methodology, setting of the

research, participant selection along with procedures I utilized to address the research question. I also included discussions of the ethical guidelines that were implemented to ensure the safety of each participant as well as measures taken to protect confidentiality. Finally, I explained all data collection instruments that were used, along with issues of trustworthiness. I will discuss the results of the research, a description and analysis of the data, and the interpretation of the findings of this study, in the following chapter.

Chapter 4: Research Results

Introduction

The purpose of this phenomenological qualitative study was to investigate and acknowledge the lived experiences of young adult Latina women dealing with mental health issues and the impact of culture on their experiences. My research question focused on what role culturally specific interventions play in healthcare initiatives to address mental health issues experienced by young adult Latina women. This chapter includes discussion of the setting of the interviews, demographics of the participants, data collection, data analysis, and the internal validity of the study.

Setting

Semi structured interviews were conducted using Zoom web conferencing with 12 young adult Latina women, ages 18 to 35, living in New York City. I did not conduct in-person face-to-face interviews due to the current COVID-19 virus restrictions. I allowed the date and time for each interview to be decided by the participant. I conducted the interviews from my home where I was alone. I asked each participant to be in a setting where they felt most comfortable and had the privacy they needed.

Demographics

The participants I chose for this study were from one of the five boroughs of New York City. I selected three of the participants from Brooklyn, three were from Manhattan, and six were from the Bronx. I did not receive a response from any Latina women residing in Queens or Staten Island. I chose the age range of the participants to be between 18 and 35. The nationalities of the participants were Dominican, Honduran,

Panamanian, and Puerto Rican. All the women spoke English and were actively receiving or were in pursuit of obtaining mental healthcare resources. The following table provided the demographics of the participants.

Table 1

Demographics of Participants

Participant 1	**Female**	**Puerto Rican**	33	**Manhattan**
Participant 2	Female	Puerto Rican	22	Manhattan
Participant 3	Female	Dominican	26	Manhattan
Participant 4	Female	Dominican	19	Bronx
Participant 5	Female	Dominican	30	Bronx
Participant 6	Female	Dominican	35	Bronx
Participant 7	Female	Puerto Rican	25	Bronx
Participant 8	Female	Puerto Rican	27	Bronx
Participant 9	Female	Honduran	31	Bronx
Participant 10	Female	Panamanian	29	Brooklyn
Participant 11	Female	Panamanian	23	Brooklyn
Participant 12	Female	Panamanian	34	Brooklyn

Data Collection

The participants I chose for the study were recruited using a flyer, which included my name and Walden University email address. I placed the flyers in the client waiting for areas of a New York City Department of Social Service Agency. Once the potential participant responded to the flyer by email, I sent a reply email containing the consent form. There were initially15 participants recruited for the study; however, I determined three individuals were ineligible for the study due to their age and not being involved in any mental health resources. I sent the ineligible candidates a thank you email for considering the study, and why they did not fit the study's criteria for inclusion.

The 12 participants I identified as being eligible to take part in the study were sent a consent form through email. The email contained directions to read the document and reply with their consent via email within three days. I also included a list of support resources for the participant in the unlikely event they incurred any emotional distress from the interview. I asked each participant to provide a time of their choice when they would be available for a virtual interview on a device of their choice. I emailed a Zoom link to the participant once the date and time were confirmed with the participant.

I conducted semi structured interviews from August 14, 2021 through November 13, 2021. The IRB approval I received, and my interview guide outlined in Chapter three (Appendix C) was used. I interviewed each participant once. Nine participants participated from their home setting, three of the nine were in the home with their children during the interview, and three were alone in their workplace.

The interviews lasted between 30 to 60 minutes which was based on the depth of responses from the participants. The variation in time occurred due to the lengths of the responses from the participants to the interview questions. I used my voice recorder on my computer to record with Zoom audio recording. I did not experience any issues with the voice recording tool. No device interruptions took place during the interviews that could have negatively impacted the interviews or data analysis. There were no distinctive circumstances that affected the participant's accounts of their encounters, such as interruptions from work or family, at the time of their participation that may have an impact on the explanation of the research outcomes.

The interview guide consisted of three demographic questions and 13 interview questions. Ten of the questions had prompts or additional probing questions that could be used if necessary. When I began each interview, I greeted each participant and informed again about the purpose of the study involved, what their participation involved, and that they still had the option to not participate in the study. I then informed the participant when the actual recording had begun.

I audio-recorded each interview using the voice recorder on my computer along with Zoom, and I informed the participant of when the recording began. I took notes of keywords and my thoughts during each of the interviews. I informed each participant at the end of the interview that the recording ended once the final interview question was answered. I then thanked each participants at the end of the interview.

I transferred each audio interview file immediately from Zoom to my computer, which is password-protected and placed in a specific project folder. I then deleted the audio files from Zoom. I reflected on the interviews by noting any possible biases, thoughts, or questions I have had in my notes.

I did not pursue any follow-up interviews with the participants. I also asked each participant if they would like to go over their interview in case they felt apprehensive about any of their responses. No participants chose to go over their interview; however, three participants asked if they could be informed of the outcome of the research study, and I was thanked by all participants for their inclusion in the study.

Data Analysis

Alase (2017) noted the objective of the qualitative approach IPA was to provide thorough assessments of personal lived experiences. IPA creates a description of the lived experience based on that experience alone rather than theories that have been established (Alase, 2017; Engward & Goldspink, 2020). As I examined the detailed experience of each participant, there was a potential for reactions that were hard to express; therefore, the qualitative approach I chose was a supportive methodology for examining the participants' experience with seeking mental health resources. Engward & Goldspink (2020) notes the research topic can bring about different emotions for the participants.

Alase (2017) seven-step process of IPA was used to explore the data set of the 12 interviews to locate the replicated patterns of meaning. For Step 1 of the IPA, which is to become more accustomed to the initially collected data, I began reviewing each interview and expanded on the notes taken during the interview process, Engward & Goldspink

(2020) notes is step 2 of the IPA process. I made and highlighted additional notes of words and phrases that stood out from the interviews. Postholm & Skrøvset (2013) noted to direct early reactions, thoughts, beliefs, and reflections, reflexive journaling should be used. I used this method.

Alase (2017) discussed for step 3 of IPA, to develop emerging themes, I started coding the data. Coding is breaking down interview data into smaller segments and identifying and categorizing phrases and themes (Sutton & Austin, 2015). In preparation for the coding process, I transferred the data from the 12 interviews from the protected file on my computer to NVIVO. I began the first round of coding once I uploaded the data into the NVIVO software. I attached specific wording and phrases to the answers from the participants for the first round. (Sutton & Austin, 2015For the next round of coding, I started narrowing down the codes by mixing them around and blending them).

Sutton & Austin (2015) note from the first round of coding the identification and conceptualization of themes and patterns begin. From the first and second rounds of coding I found small phrases and keywords in the participant's answers. I pinpointed four possible themes for later assessment: obstacles to healthcare resources, the influence of culture on knowledge of resources, slow use of healthcare resources, and negative attitudes and healthcare. Step 4 of the IPA process is to look for links between the themes (Alase, 2017). I began considering the initial themes and imagined how they could be viewed in other contexts, such as the impact culture plays on a young adult Latina woman's use of healthcare. Cultural influences from her past or present could affect how

she views seeking out healthcare resources. I also blended the wording of the themes to ensure the responses from the participants were well represented.

The fifth phase of the IPA process involves the researcher managing the time spent with each data set to not muddle the data (Alase, 2017). As each data set was completed, I made notes accordingly and waited 2 to 3 hours before I moved on to the next data. This was done to clear my mind from the prior information and be able to have a separate perspective on each participant.

Step 6 of the IPA process is finding patterns in the collected data (Alase, 2017). I noted similar responses that the participants shared when I reviewed the interview data. I noticed several of the participants stated they had a problem due to a language barrier. The final step of IPA is to analyze the data on a deeper level (Alase, 2017). I took the participants' precise statements from the transcripts, and my interpretations of their responses, to get to the fundamental meanings of their lived experiences.

Confirmation of Trustworthiness

Demonstrating trustworthiness in a research study provides validity to the results of the research study (Campbell et al., 2020). In qualitative research, trustworthiness is established by exhibiting that the investigation has consistency, and accuracy, and is comprehensive through analysis (Campbell et al., 2020). I used various strategies during the research process. I did this to ensure dependability, confirmability, transferability, and credibility were attained.

Dependability

According to Campbell et al. (2020), trustworthiness takes place when a researcher documents the research process in the event the study is duplicated by another researcher, similar results can be produced. Detailed record keeping describing the reflexivity of the researcher, research design, and detailing the procedure are tactics used for dependability (Campbell et al., 2020). I kept detailed notes and data collection undertakings during the research process.

Confirmability

Confirmability is obtained when the researcher establishes that the data, and how the results of the data are interpreted, have only been concluded based on the data alone and not from the researcher's thoughts or beliefs (Campbell et al., 2020). I created tables to demonstrate how themes transpired from the data using phrases and keywords from the recordings and my notes of the participants. Fully acknowledging my role as a tool in the research process, I intentionally engaged in reflexivity during the data collection and data analysis process to decrease bias in personal feelings, experiences, and thoughts. With my using interviews, reading materials, and visual analysis, triangulation was also applied during the research process to optimize objectivity.

Results

The data I gathered from the participant interview responses were used to answer the research question: What role do culturally specific interventions play in healthcare initiatives used to address mental health issues experienced by young adult Latina women? I distinguished eight themes, which I listed in Table 2 below, from the

participant interviews that contributed to the role culturally specific interventions play in the healthcare initiatives used to address mental health issues experienced by young adult Latina women.

Themes I distinguished include Theme 1: The relationship between low income and healthcare resources; Theme 2: Limited knowledge of healthcare resources; Theme 3: Cultural attitudes shape engagement in mental health resources; Theme 4: Negative attitudes with engagement in mental health resources; Theme 5: Obstacles to mental healthcare resources influence engagement in resources; Theme 6: Cultural influence on the promotion of mental health resources; Theme 7: Minimal engagement with healthcare resources; Theme 8: Ongoing engagement with mental health resources.

Table 2

Identified Themes Extracted from Analysis

Themes Extracted	Main Codes identified	Secondary Codes identified
The relationship between low income and healthcare resources	Insufficient access to mental health resources, effects of inadequate access, correlation between low income and healthcare resources.	Adds to stress, difficulty of transportation, income is a big factor, you get treated differently, hard to access resources. This causes issues, how can we pay for medications, copay, so hard to find, stuck.
Limited knowledge of healthcare resources	Knowledge of healthcare resources are minimal, insufficient, poor notification of available services. Basic.	Knowledge of healthcare resources were minimal
Cultural attitudes shape engagement in mental health resources	Health issues not discussed openly, feelings of shame, prefer to look for help on their own. Don't really like asking people in the same culture for help. Don't want people knowing my business. People act funny, they are old fashion. That is how we were raised.	Shame, scary, embarrassed, private, negative attitudes, culture. Family, stigma, knowledge, individual personal, influence of upbringing, behavior
Negative attitudes with engagement in mental health resources	Too many other problems to worry about, doctors not very understanding. Issues with health coverage. I feel angry, more depressed, very personal. People make you feel bad	Knowledge, lack of money, invaded, location, not trusting, cultural influences, insecurity, loneliness, sadness, communication
Obstacles to mental healthcare resources	Services hard to find, family unsupportive. Insurance copay,	Money, attitude, information, family, professional, work

	influence engagement in resources	employment, health insurance not accepted.	schedule, themselves, bipolar, depression, stressed out, tired
	Cultural influence on the promotion of mental health resources	Other people's ideas, receiving wrong information, not talking to people. Don't want to ask for support, afraid for people to know. Stigmatized, education, neighborhood. Ethnicity, bad information	Family, personal, religion, support, worry, community, problems, disagreement, doctors, abuse, hospitals, money
	Minimal engagement with healthcare resources	Change in health coverage, my medication was not covered. Could not find services, new employer did not provide good coverage, doctor misunderstanding, there needs to be more doctors in the neighborhood we live in. it takes a long time to get to see someone, medication cost, quality of service	Impacted, consequences, language barrier, disrespectful, location of office, scheduling, copayment, finances, family, work, health insurance, attitude.
	Ongoing engagement with mental health resources	I need to be respected. I want to be better. You need to see that things are working, knowledge of culture, better services, health coverage should be better	Improvement, trust, access, respect, caring, bilingual, affordable, location

End of Table 1

Theme 1: The Relationship Between Low Income and Healthcare Resources.

The participants I recruited described the relationship between low income and healthcare resources and how this relationship influences accessible resources. The relationship between low income and healthcare resources was identified as negative by all the twelve participants interviewed. P2 said, "You don't get the best care when you

don't have money or good insurance." P3 said, "A lot of the doctor offices in the poorer neighborhoods don't give good help." P5 said, "You really don't think you will get good help with medical stuff if you have no funds." P6 said, "I really don't even want to go to any clinics in my area. They look rundown, especially like the pharmacies, things never in there you need."

P8 said, "I have tried sometimes to get Dr. appointments and when they ask what you have, what insurance you have and you say Medicaid, now it's nothing available. Before everybody take Medicaid, now it no good." P4 had a similar response to P8 saying,

> When I use to just have Medicaid it would sometimes be hard to get to see doctors downtown, you know the specialist doctors if you have to get the referral, now I see with the insurance I have now they are ready to bring me right in, yeah it's different, but ok.

P1 said,

> You would think it would be better than before but whatever no. I still feel like I'm getting treated like how you call low class, like what like I am a step above homeless people? If I use Medicaid, it is still to see the doctor, I should still get help. See what I'm saying?

Participants 10 and 12 also had similar responses. P10 said,

> I just can't believe why it's with the difficulties. Why if you need some help, you need to see doctor, you still need to go so far? They should have these things right here for you. One time the only doctor that take me was all the way out in Long

> Island. I could not pay all the time to go all the way out there. No good." P12 said I don't see how you are expected to make it to these clinic offices that are out of the way. I don't like going to the nasty ones in my area. They are nasty inside. That is what we have in my area. But to have to travel so far just for it to be good.

Three participants. P7, P9, and P11 spoke specifically to the relationship between low income and accessibility to healthcare resources and the impact it has on their mental health. P9 said,

> There definitely is a connection between being poor and how you are treated as a person who is looking for assistance. Then you throw on top of that not speaking the language good either. That makes you feel stressed out. I don't want to go somewhere that they make you feel like you begging for help or don't know what you talking about, especially like at the clinic where you need the help. That is so stressful.

P7 said,

> It makes me feel so bad when I get told that I have to see a different doctor. When you go to the hospital over here for appointments it's like whoever is there that day you see. For me I have the bad anxiety. Every time over and over I have to explain to a new person. But I know it is just in these crowded hospitals. But is close to my house.

P11 spoke candidly about her issues with mental health. She said,

> With me dealing with my own mental health stuff, being Bipolar, I don't have time to play with people and they attitudes. I can get upset real bad and I know

> that. I'm telling you whenever I go to my doctor, he is in a nice place you know his office is nice, but you know he take in different people, I know I have Medicaid. They make you feel like, when you go in for your appointment, that it's bad if you show your Medicaid card when they ask for your payment. Really, I mean I have to get myself ready so I don't go off at the front desk cause I like the doctor but the people there they make you don't want to come in there to feel funny. Like they don't want to see people who have public assistance. That's real bad how they do people.

The participants' identification of negativity in the relationship between low income and healthcare accessibility contributes to the need for culturally specific interventions to support the mental healthcare needs of young adult Latina women.

Theme 2: Limited Knowledge of Healthcare Resources.

I asked the participants about what they knew about locating the healthcare resources they needed, and if they could name any that they recalled. Five of the participants could list the name or names of resources they had knowledge of. Three participants identified two resources, and four of the participants could not recall any healthcare resources. For the participants who did not list any names of healthcare resources, two of the participants, P7 and P9 said that if they needed to locate a particular resource, they knew they could ask around for help to find one. P7 said, "If I need to go get help, I know who I can ask to help me." P9 said, "I can't think of any right now." When I asked, many of the participants could not name many healthcare resources for mental or physical health. This indicated to me a lack of knowledge on healthcare

resources that were available for use, and why there is a need for information on how to acquire information on resources that are available for use.

Theme 3: Cultural Attitudes Shape Engagement in Mental Healthcare Resources.

Overall, the participants understood and stated that there indeed was a need for mental healthcare knowledge; however, many of the participants did not recognize that the rate of promoting knowledge of mental healthcare resources was related to their cultural upbringings and their current cultural surroundings. Four of the participants explained that in the Latin culture most people did not speak openly about any health problems they were having and stated this is how people still feel today. P12 said,

> I can remember from when I was younger, you know they would tell you to go from the living room, outside or something, when the grownups talk about things, you know like that. You know you have somebody crazy in the family, you know nobody want to talk that, they don't want to say these things around a lot of people you to not get it around. But I know I see that this is no help. It don't help when you hide those things you know. It could be somebody to help you if you ask, if you say something.

P1 said,

> If you grew up all of your life around people, or family who worry so much about what I call the outside, no you can't say or they must not know, and then you are like, they train you to not even say anything. They don't even have to tell you no more to not say anything, you just know, see?

P5 also shared,

> Oh my god. How do you do that right? My people they still so shy today, scared. I don't know to ask somebody oh no, no way for real. I don't even want to tell nobody in my family that. It is good I can look it up or have other places to ask.

Many of the participants demonstrated a significant amount of understanding of the cultural attitudes influencing their engagement with mental healthcare resources.

Every participant I interviewed recognized some type of cultural connection to their knowledge and use, or lack thereof, of mental healthcare resources. P10 said, "I know who I can ask questions to, and I know who to leave alone." P8 said, "Older people in my culture they still would not want to discuss this. I know I would get know help there you know if I thought let me go talk to somebody wiser, you know." Due to the impact of the culture, each participant has and is currently experiencing, interrelationships between the participants revealed themselves.

Each participant I interviewed remarked that they had a negative experience with another nationality in the Latin community. There was a common ground with each participant on the role culture played in their engaging with or seeking out mental healthcare resources. The limited engagement with mental healthcare resources could be with concepts perceived by the participants from the cultural environments that made significant impressions on their lives. These young adult Latina women were not engaging in mental healthcare resources without realizing the impact of their cultural environments which could also contribute to the lack of knowledge of mental healthcare resources.

Theme 4: Negative Attitudes with Engagement in Mental Healthcare Resources.

There were many different thoughts expressed by the participants on negative attitudes toward engaging with mental healthcare resources. Two participants stated how bad it made them feel that they needed this type of help. P3 said, "It was a hard thing to do, admit to myself that I even needed help for myself," and P2 said,

> To have to share that information with people, you know sometimes, it's just saying out loud like that, it makes me sad. It makes me angry too. You know when I go in person in a doctor office I get so like depressed when I leave to go home. Even in there talking to a doctor, if it is hard to explain what I am going through, that make me feel crazy too. I don't know.

P6 talked about many reasons why Latinos do not feel optimistic about using mental healthcare resources. P6 said,

> Maybe because like if you go to a counselor or something like close to your area people be nosey, all minding your business you know. You know people so bad they will ask you what is wrong with you try to learn your business. You tell them no it don't matter people will make things up on you. That's why you know you don't want people talking about you.

P8 stated,

> Who even has time to worry about these things? I have so much more things I have to worry about. Sometimes it's just too much to have to deal with. But I do feel sometimes so bad I do need to tell somebody. It just too much all the time.

The young adult Latina women had many reflections on the negative attitudes in engaging with mental healthcare resources. Their negative reflections went from a degree of how they were viewed by others for needing the services to how they viewed themselves. The participant responses confirm there remains a need to continuously examine this population of women to gain a clearer understanding of the supports they need to assist them with developing trust and adaptability in mental healthcare resources.

Theme 5: Obstacles to Mental Healthcare Resources Influence Engagement with Resources.

Many of the participants disclosed personal and basic encounters they had with seeking out mental healthcare resources and how that influenced their engagement with mental healthcare resources. The experiences the participants had ranged from self-doubt, family support, and mental health facilities. To continue to support the confidentiality of the participants, I will not disclose any personal identification of family member names or relation to the participants that were mentioned during the audio recordings. P1 candidly shared her experience with being bipolar and how this mental disorder places her in such a depressive state that she, on occasion, missed appointments with her doctor because she did not have the energy to go. P1 said,

> The day before my appointment, and I tell you I could have everything all set, my clothes ready, I set up my car service, I shower, I eat, and then boom, nothing. I lose my concentration; I can't even get in the right mood to go. Then when I don't go, later I'm mad and crying, I don't like that.

P5 spoke openly about her suicide attempt and how her living with her family and their disappointment with some of her life choices influenced her engagement with mental healthcare resources. P5 said,

> Growing up and living with my parents still as an adult was very difficult for me. I still lived with them because they were very sickly. I had to help take care of both. They each die a short time after each other. My parents were both from the Dominican Republic. So, they were very strict and very religious. They talk about everything I do wrong, wrong work, wrong partner, I have a girlfriend, big no-no. Anytime I talk about how I feel, if I didn't like something, if I broke up with somebody, they always tell me it is my problem, that I have a problem, everything my fault. Once I was talking to my sister about getting help and my mom tells me to stop doing stupid things, like that solves everything. Back then, before I really wanted somebody for help, but my own family made me feel like I couldn't go nowhere to get help. My own mother and father.

P12 mentioned how she never would let any one of her siblings or her mother know she wanted to seek therapy for how stressed and overwhelmed she felt after she had her daughter. She believed they would think she was not a good mother. P10 discussed the first time she went into a doctor's office to speak to someone after the death of a close cousin. She spoke about how she left the meeting confused and misunderstood, believing it was due to the language barrier between her and the doctor.

P10 said,

> I had a cousin I grew up with we were very close. She was killed by her boyfriend when we were twenty years old. I knew him he go to jail. When I was telling this to the therapy lady, she ask me questions like how I was feeling, how my cousin death make me feel? I think like she thought I wanted to kill myself or something. That was not the problem, not my problem. I was talking to her because I stayed mad for a long time. I felt angry all the time. I leave that meeting upset with that lady. I talk to a minister in my friend church for a while, but I really want to talk with somebody else, you know a professional.

Theme 6: Cultural Influence on the Promotion of Mental Healthcare Resources.

Several of the participants provided information for the theme of cultural influence on the promotion of mental healthcare resources. Ethnicity and family were the two most focused cultural influences mentioned by the participants. P3 said,

> Coming from a very religious background, well my family, they often look to the church for support first. For me not my first choice to talk to the priest. She felt strongly that culture played a large part in how she viewed things as an adult.

P8 said

> I knew growing up I worried too much about what people from my culture would think, and not just my family, people in the community, you know. I mean like friends of the family. It's crazy you know if enough people don't like something, they don't agree with something, everyone go that same way. To talk about problems, you are having like your husband beating on you, you are never to

> discuss, that stay in your house. You feel unhappy they say things will be fine. Never do they think to say maybe you go to doctor, or to talk to somebody to get help.

P4 shared her thoughts. She said,

> Even when you are feeling sick you never hear oh you should go to the hospital. It's the same old way. That's why I think before like for my mother and grandmother things could have been better if they look outside for help, I thinkWhen all you grew up with is stress, people around you struggling, you don't think anything is different, to think to look or ask for help, you thinking that's just it.

P8 said, "I grew up with a family that my mother use drugs, other family was abusive, nobody tried to help nobody do better."

Theme 7: Minimal Engagement with Healthcare Resources.

Five participants experience some form of engagement with mental healthcare resources. Only two of the participants engaged with the resources for a significant period. Their reasons for minimal engagement with mental healthcare resources ranged from lack of health insurance to cover the expenses to a lack of providers available for use. P1 discussed how a change in employers impacted her ability to continue with the support she was receiving. P1 said,

> Right when I started to feel comfortable with a therapist, I had been seeing I changed jobs and I was under a different health insurance, and now you know this new guy, he did not take the new insurance, before I just had Medicaid. They try

> to still help me with some other program, but it still didn't work with new insurance.

Another participant spoke about the difficulty of finding Spanish-speaking doctors with whom she felt she would be more comfortable and open. P9 said,

> I don't find many of these psychologists, therapist people that understand where I come from, you understand? I don't think they get me, so, that makes me not want to keep up with it cause it makes me feel funny, you understand?

P2 shared her thoughts. She said,

> I don't see too many of the programs. Then, if I do, I must wait long times to see someone. I mean even for the appointment." One participant mentioned that she thought she had found a mental healthcare resource, but it was not for one-on-one sessions, it was shared group therapy, and that did not appeal to her.

P5 said, "I wouldn't know those other people. Don't get me wrong. It wasn't bad what they were doing, but I just didn't like my thoughts out in the open like that." P10 said, "My insurance needed a copay too. It was becoming a lot."

Participants 1 and 12, who spent a little more time engaging with mental healthcare resources, had consistency issues. There was always a break in between the use of services or changing of resource provider. P12 said, "Two times I was going to clinics for help, and they closed down or moved. That made things hard for me to stay with it." P1 said, "I would go and see my doctor on schedule many times, but I feel sometimes like it's no good. It don't feel like anything getting better. Then I don't go

again.”Many people who need mental healthcare rarely receive the help they need or are even aware that is the type of help that they need (Ruiz et al., 2016).

These young adult Latina women are up against many obstacles which are preventing them from accessing the mental healthcare resources that they require. Their responses further indicate the disparity these women are continuously experiencing, and why there remains a need to provide quality care and access to mental healthcare resources for young adult Latina women.

Theme 8: Ongoing Use of Mental Healthcare Resources.

Each participant stated that if the circumstances were favorable that they would be more likely to be more persistent with seeking out and using the mental healthcare resources available to them. P9 said, “I can tell my kids get upset when I’m not feeling so good or like when I am yelling at things for no reason. I know that is not fair to them. I just wish things wasn’t so hard to see somebody.” P4 said, “I would like to do better with seeing somebody. Yes, I know it would be good for me.” P10 said, “If I find a doctor, I feel like could understand me that would make me try, as long as I don’t feel like I am being disrespected.” P2 said, “I don’t mind seeing new people, I already know what that is, but it would just help me if they were from my people. I would, I would just feel more better to share.” P6 said, “You know when I look at the news and stuff today, I hear them tell that there are services out there but where? I really don’t see that. Where are they at? I will use them but then that’s the thing. How far do you have to go?” Participant 12 spoke about the treatment of Latin people today. P12 said,

> You have to understand too that not everybody trust like that you know people in power. I am saying it's just a lot of things you have to be careful about. I know now there are things I can look up for myself, on my own, so if that works, and I know more about the place or they have ratings for the doctors, I can see going ok.

P9 said,

> One place I went to the doctor prescribe me this medication and I could not pay for that one. I don't want that. Like I think they take advantage. They did not offer the no-name kind like I know I get for my children, but any way, I want to be respected. Don't treat me like a project. I will go I wouldn't be scared to go.

Participant 3 mentioned how she needed a bilingual practitioner. P3 said, "As long as they speak both languages, both Spanish and English, that is good for me. That would have me going back."

With the rate that young adult Latina women are still struggling with accessing mental healthcare resources and with so many suffering in silence, more effort must be made, and initiatives put in place to give these women access to quality, culturally competent, and affordable mental healthcare resources.

Summary

The purpose of my phenomenological qualitative research study investigates the need for culturally specific interventions for young adult Latina women. This is to provide support for their mental health issues. I used IPA to analyze the collected data and eight themes were produced from that data. The themes I distinguished included the

relationship between low income and healthcare resources, limited knowledge of healthcare resources, cultural attitudes shape engagement in mental healthcare resources, negative attitudes with engagement in mental healthcare resources, obstacles to mental healthcare resources, cultural influence on the promotion of mental healthcare resources, minimal engagement with healthcare resources, and ongoing engagement with mental healthcare resources.

With the data collected from the twelve interviews, I concluded that young adult Latina women continue to experience inadequate access to quality mental healthcare. The young adult Latina women who participated in the study communicated several factors that continue to shape their views on why they still struggle with finding and engaging in quality mental healthcare. For the most part, the young adult Latina women who were interviewed acknowledged the necessity of mental healthcare; however, simultaneously, they acknowledged the difficulties that/ went along with finding and utilizing quality mental healthcare.

The difficulty the participants had with naming any known mental healthcare resources demonstrated a need for more promotion of mental healthcare resources that may be available. This lack of knowledge on the part of the participants contributes to the lack of engagement with mental healthcare resources. In Chapter five I will discuss the interpretations of the findings of the study, and I will provide recommendations for future research. Social change implications will also be discussed, ending with the conclusion of the study

Chapter 5: Discussion, Recommendations, and Conclusion

Introduction

The purpose of this phenomenological study was to provide support to young adult Latina women. Young adult Latina women need quality mental healthcare that is culturally sensitive and accessible healthcare to provide support for mental health issues such as depression and anxiety. Practitioners and policymakers must gain a better understanding of disparities young adult Latinas face, such as the availability of mental health resources, so that effective programs and initiatives can be developed and implemented. Bronfenbrenner's ecological systems theory was used as the conceptual framework in this study because practitioners can follow this framework to examine the mental development of young adult Latina women based on how they are impacted by their interactions with their surroundings. Bronfenbrenner's theory could also assist policymakers and practitioners to understand why culturally specific interventions are needed to assist young adult Latina women with engaging in consistent support programs.

Bronfenbrenner's ecological systems theory could show how culture influences young adult Latina women's perception of their negative experiences. I used this theory to guide the development of the research question to inquire about how culturally specific interventions could be used to address mental healthcare issues experienced in young adult Latina women. This chapter will include the analysis and interpretation of the collected data results from Chapter 4 to demonstrate the connection between the literature

review and the conceptual framework. My study's limitations, recommendations, and implications will be discussed. Lastly, a summary of the study will be provided.

Interpretation of Findings

The research data I collected for the study revealed that several components contributed to the lack of medical healthcare resources used by adult Latina women. The eight themes I distinguished from the data collected were: (a) the relationship between low income and healthcare resources, (b) limited knowledge of healthcare resources, (c) cultural attitudes shape engagement in mental health resources, (d) negative attitudes with engagement in mental health resources, (e) obstacles to mental healthcare resources influence engagement in resources, (f) cultural influence on the promotion of mental health resources, (g) minimal engagement with healthcare resources, and (h) ongoing engagement with mental health resources.

The young adult Latina women interviewed demonstrated knowledge of mental healthcare and understood the relationship between low income and accessing healthcare resources. P10 said, “When you don’t have money it’s hard to get to places, you know, doctor offices that take good care of you. Especially if you have no insurance.” P4 said, “You know you don’t get good help at these places unless you can pay a lot of money, that how it is. So, if you don’t have the money you don’t go.” The participants had thoughtful attitudes when it came to mental healthcare engagement. This was demonstrated by their remarks on the importance of mental healthcare resources, and how mental health impacts the family, work, and everyday life. P1 said, “I know I stress

my daughter out too because I'm bipolar and when I have those days, I see how it bothers her. That's why I try to keep up with going to appointments."

The participants identified a positive point of view on mental healthcare resources by sharing how they will begin seeking out and using the mental healthcare resources that are provided for them. The young adult Latina women also recognized their involvement in the use and nonuse of mental healthcare resources. The acknowledgment of their involvement in the use and lack of use of mental healthcare resources is important because of the extent to which they participated in mental healthcare interventions. These interactions affect the rate at which they need culturally specific interventions can be examined.

Findings Related to Literature Review

I used IPA during the data analysis process to discover eight themes. The themes were (a1) the relationship between low income and healthcare resources, (b2) limited knowledge of healthcare resources, (c3) cultural attitudes shape engagement in mental health resources, (d4) negative attitudes with engagement in mental health resources, (e5) obstacles to mental health resources influence engagement in resources, (f6) cultural influence on the promotion of mental health resources, (g7) minimal engagement with healthcare resources, and (h8) ongoing engagement with mental health resources.

The Relationship Between Low Income and Healthcare Resources

Establishing the young adult Latina women's ideas and perceptions of the relationship between low income and healthcare resources was key in helping demonstrate its significance. Several of the participants discussed how their low income

was a major factor in their use of mental healthcare resources. In previous studies, researchers focused on the relationship between income and access to healthcare resources. If no relationship existed between low income and healthcare resources, it would not be necessary to have culturally specific interventions to support young adult Latina women. Prior research studies recognized the relationship between low income and healthcare resources as recurring and directly associated (Dillon et al., 2018; Fendt-Newlin et al., 2020; & Ramos-Sánchez, 2020).

My study's findings reflected previous findings because the young adult Latina women directly discussed the relationship between low-income status and healthcare resources as a direct stimulus and response. Many of the participants explained that their lack of income contributed to the mental issues they were experiencing and described the stress and tension they experienced. The experiences of the participants supported the concept that low-income young adult Latina women are disproportionately impacted by issues with mental healthcare resources.

The data I collected shows the impact of low income could also be related to the inconsistency in the treatment received in mental healthcare. According to Ramos-Sánchez (2020) the increased suicide rate among young adult Latina women could be attributed to untreated mental health issues. Some of the participants discussed their suicidal thoughts. P1 said,

> When I was thinking about how wrong I thought everything was in my life and I didn't want to go through that stuff no more, I don't know I just didn't want to be here. I was just tired of dealing with everything and everybody. You know. Then I

> just didn't know who to talk to how to get help. It's still hard to look back at some times that I tried to kill myself.

The experience of P1 trying to commit suicide aligns with previous findings related to how young adult Latina women who experienced impoverished situations and suffered from mental health issues are heavily impacted. Bruzelius and Baum (2019) showed that most young adult Latina women believed that having a low income can play a significant part in the nonuse of mental healthcare resources. Additionally, previous research showed young adult Latina women who did not receive their required mental health treatment ran the risk of being exposed to a longer period of suffering and a higher rate of remaining in a lower income bracket due to their instability.

Young adult Latina women who fell into low-income brackets could be more vulnerable when it came to experiencing mental health disparities. Young adult Latina women were more likely to experience obstacles seeking mental healthcare (Dillon et al., 2019). The present research study corroborated earlier research studies, specifically relating to the availability of mental health resources. P3 said,

> Of course, having no money is part of the problem. I know it is for me and other people I know. I feel like if you have the money, you have a better chance. You get better service better help. I know I find better places even cleaner places.

P9 said,

> When you don't have the money, you need to take care of the things you need to take care of that makes you feel bad and yeah, I get depressed about that, and makes me worry a lot. I know that brings me the anxiety.

This statement from P9 supports previous findings that having access to quality mental healthcare is a consistent issue for young adult Latina women who are in the low-income bracket

Young adult Latina Women and Knowledge of Healthcare Resources

Barnett et al. (2016) noted that young adult Latina women had limited knowledge of healthcare resources. I found in previous studies that although mental healthcare does exist, information promoting the existence of the resources was not readily available for young adult Latina women (Cabeza de Baca et al., 2018: Ruiz et al., 2016). In this study, several of the participants—P3, P5, P7, P9, P10, P11, and P12—noted they had limited knowledge about mental healthcare resources. This limited knowledge contributed to the low rate at which adult Latina women engaged in mental healthcare treatment. Barnett et al. (2016) noted people sought treatment when there was knowledge of the support and resources. Cabeza de Baca et al. (2018) stated that when people used healthcare resources and saw that it was something beneficial to their well-being, the resource was utilized at a higher rate and outcomes were more favorable.

Four of the participants mentioned they knew about one or two mental healthcare resources. Eight participants could not name any mental healthcare resources. Their responses supported prior research concerning the limited knowledge that young adult Latina women had about finding mental healthcare resources (Barnett et al., 2016). Seven participants acknowledged that mental healthcare treatments would be beneficial in supporting their day-to-day lives.

Cultural Attitudes and their Impact on the use of Mental Healthcare Resources

Data on culturally specific interventions for young adult Latina women are limited (Shuey & Leventhal, 2018). For that reason, my research study was conducted on the effect cultural attitudes have on young adult Latina women engaging with mental healthcare resources. At the beginning of the interviews, the participant's ideas about cultural attitudes appeared to be similar. The interview responses included statements about older people in their culture being stuck in their ways. P4 said, "you don't discuss these things with family, you feel like you must keep things to yourself, and this is not how we do things."

Participants 1, 5, and 12 had similar comments as they related to mental health and family culture. P1 said, "I knew I could not ask my older people in the family questions or even let them know I did not feel well." P5 said,

> I think I would make them feel embarrassed and I wouldn't want to do that. I wouldn't want them to think of me different because I respect my grandmother and my mother and aunts. I have other older family members but I just could not talk to them like this.

P12 said, "Oh no I would not give them the idea I had problems, that I was not feeling well. There is nothing they would do to help anyway." P6 and P9 shared childhood memories that were alike. P6 said, "when I was younger my mother told to her sister why would you tell people about that? You want to make everybody look crazy? You don't disrespect your husband. You don't make your family look bad." P9 said,

> I saw how my mom was. I knew she was holding a lot to herself. I used to feel so bad. She would be sad a lot but she would always say no it's okay you know, I don't think she trust a lot of people like that."

All the participants provided a concise response to the impact of culture on the use of mental healthcare resources. P2 said, "As soon as they know your business, they are talking then everybody knows it family friends or whoever." P3 said, "I know I just have to keep to myself. Most of the time people don't want to know you have problems." P4 said, "I feel like it would give me more stress knowing that people are saying bad things about me or telling my family things about me." P7 said, "I worry a lot because I don't want people to say things around my kids. I don't want them to hear things from people around me, from my family." P8 shared her story. She said,

> See this is what gets to me is that it be your family people you think they for you. I mean how can I say it. People who come from where you come from, they tear you down too. I thought staying around people from my own culture would be good but it's not like that.

P5 said,

> I find it funny you know but not really, if you helping somebody, you doing something good for people of my culture you are blessed, you are good in their eyes. When you are in trouble you are struggling or you are not well, like your problems will make them look bad. That was my grandmother hard to explain things to.

P10 said, “You always have to think about your family. They help you I do not disrespect my people.” P11 said, “I know it can be difficult, but I don’t want them to think bad of me.”

Participants 1, 6, 9, and 12 were more in-depth with their responses associating family and/or the community attitudes toward mental healthcare resources. P1 said,

> I had people in my family tell me to my face I was crazy. I have gone off on people in my family before, but I was not diagnosed back then with bipolar. I know they didn’t know how bad I was back then either, but they didn’t care about how I was doing. It was just for them to blame everything on me.

P6 shared her thoughts on the attitudes of others on mental health resources. She said,

> Even when you don’t know everybody in your community they know you, they know people in your family. You can tell by the way they ask you something that somebody say something to them about you. I stay to myself. I speak to people show no disrespect, but no matter, I know they talking about me to my family. If I go to the doctor that is not for anybody business.

P9 also shared her point of view. She said,

> I have seen people not from my culture e treating people funny cause you don’t speak the language that good, so when you have people from your own culture treating that way, you don’t want to trust anyone. You feel like your problems are your problems. You don’t want to ask nobody nothing and you don’t want to tell anybody nothing. You understand.

P12 said, I stop thinking I can get help from people in my family. I know I need to talk to somebody, to find help, but it is just better for me to take care of it on my own." Being aware of the obstacles was a key part of overcoming issues that were in the way of receiving help (Bruzelius & Baum, 2019). The responses of the participants demonstrated an understanding of how their cultural attitudes had an impact on their engagement with mental healthcare resources.

Negative Perceptions based on Seeking Out and/or Engaging with Resources

The participants interviewed for this study discussed the issues they had with getting mental healthcare support. Their responses indicated there was an understanding that some of the ideas they had plagued their thoughts about the use of mental healthcare supports. When question number six was asked, each of the twelve participants identified several negative attitudes they developed about engaging with mental healthcare supports. They connected the treatment they received in doctor's offices, being misunderstood, feeling disrespected, being stigmatized, and why negative perceptions were held about engaging mental healthcare resources. Past research noted that young adult Latina women who had negative perceptions of mental healthcare resources may stop utilizing mental healthcare resources (Flynn et al., 2015; Kaltman et al., 2016).

When young adult Latina women have negative attitudes toward engaging with mental healthcare supports, they run the risk of prolonging mental health issues. Young adult Latina women already experienced inconsistencies with access and the quality of care they received (Ramos-Sánchez, 2020). Research showed mental health disparities

that remain untreated for a significant amount of time can negatively impact future outcomes (Eghaneyan et al., 2017; Kaltman et al., 2016).

Obstacles to Utilizing Healthcare Resources

The twelve participants interviewed disclosed different experiences with the obstacles they encountered engaging in mental healthcare resources. Bruzelius and Baum (2019) found that it was not unusual for young adult Latina women to have difficulties with seeking out and utilizing mental healthcare supports. Bruzelius and Baum (2019) noted this was largely due to young adult Latina women not knowing the signs of having a mental health problem. Some of the participants felt their experience with obstacles to mental healthcare stemmed from not understanding why they were feeling the way that they did, like feeling depressed or anxious. P9 said,

> So many times, I didn't want to get out of bed I didn't want to see nobody. I didn't want nobody to talk to me. I even missed days from work, and I didn't know why. I just waited for it to go away.

P2 said,

> It wasn't until I tried to commit suicide, I realize I was really bad, that I had problems. Even up to that time I thought I was just being sad. If one day I was happy I would go right back to feeling down, you know.

P7 said, “The times I wanted to go it was always something, something maybe work, but that was on me. But bigger stuff like not having insurance or money to pay, I couldn't get around that." P4 said, please it's always an issue. Oh, we don't have any openings, oh we

don't take your insurance, oh we are moving to a new location. What are you supposed to do with that?"

Researchers showed a link between inaccessibility to mental healthcare supports and the slow rate at which young adult Latina women utilized mental healthcare supports. The responses from the participants supported the past and current findings which recognized that limited finances, resources, and stigmatization were obstacles. Their responses illustrated how those factors prevented them from receiving treatment they required. My findings highlighted finances as an obstacle that young adult Latina women faced when seeking out mental healthcare resources, instead of themselves or lack of other resources. The data I collected also showed that the participants acknowledged themselves as obstacles to receiving treatment

Limitations

Qualitative research is subjective because of the approach used to understand why people behave the way that they do (Carter & Little, 2007; Denzin & Ryan, 2007). A researcher can become immersed in the subject and be impacted by researcher bias. Trustworthiness and credibility, transferability, and dependability were used to show rigor in the qualitative research approach (Carter & Little, 2007; Denzin & Ryan, 2007). I supplied several steps to the research process and noted every step in my reflexivity journal. A second limitation of the study I found was the geographic location used for the study. The criteria set for the participants narrowed the inclusion of potential participants to the five boroughs of New York City, which are the Bronx, Queens, Brooklyn, Manhattan, and Staten Island. My results of the study may not be transferable to young

adult Latina women outside of these five boroughs. Future researchers may want to broaden their criteria location to provide a variety of results.

Marchel (2004) noted researcher bias must be addressed during a research study. Another limitation of the study I found was researcher bias due to me being an instrumental tool, correspondent, and examiner. I am a black female that lives and works in New York City. My employment with social services, racial identity. outlook on the world could have contributed to bias during the data collection and data analysis process. Any researcher bias that may have imparted itself in the data collection and analysis process was addressed by using reflexive journaling and research triangulation.

Recommendations

My qualitative research study represented an understanding of the experiences of young adult Latina women seeking out and utilizing mental healthcare support. The information I gathered for this study was necessary to help improve the disparities in the quality and accessibility of mental healthcare supports. All the participants interviewed for this study were from the borough of Queens, The Bronx, Manhattan, Brooklyn, and Staten Island. My study relied on a specific location; therefore, no variations to the research criteria were given. As a result, my

initial recommendation for future studies would be to gather participants from different areas in New York State. Roy et al., (2015) noted viewing data through different methods could create wider ranges of information. This supports results that are generalizable.

My second recommendation is to duplicate my research study and incorporate young adult women from various cultural backgrounds and nationalities. My focus was on young adult Latina women because of the higher rate of disparities in availability and access to mental healthcare resources. Therefore, studying my subject with young adult women from other backgrounds is recommended. My recommendation could enable data to be analyzed that covers contrasting socioeconomic characteristics (Knudson, 2015). The contrast with other characteristics would establish transferability to additional young adult women and would also contribute to the gap in the literature on young adult Latina women.

An important discovery I made in this study was that young adult Latina women wanted to engage with mental healthcare resources; however, the obstacles they faced such as their attitudes and limited finances made it difficult. Parra Cardona et al. (2017) suggested providing young adult Latina women with more equal and accessible mental healthcare resources to close the gap in availability, quality, and accessibility of mental healthcare resources. I recommend a quantitative study is to examine the hypothesis of the need for healthcare initiatives to be culturally adaptable to help improve the mental health resources for young adult Latina women.

Implications

Parra Cardona et al. (2017) mentioned that the disparities in mental healthcare resources, experienced by young adult Latina women, must be explored more, as they are not widely understood. The data I collected from the semi structured interviews provided particular information on how young adult Latina women viewed engaging with mental

healthcare resources, the importance of mental healthcare resources, and what role they played in utilizing mental healthcare resources. Young adult Latina women who understood they played a part in engaging mental healthcare resources were critical because if they did not see the importance of seeking out and engaging with mental healthcare resources, no one would see the urgency in providing them with quality and accessible mental healthcare resources (Chase & Rousseau, 2018; Parra Cardona et al., 2012; Rodriguez, 2017).

All the participants I interviewed remarked that they were concerned about the accessibility of mental health resources. In the areas where they live, mental healthcare resources are insufficient; however, there is a significant interest in using mental healthcare resources that are culturally competent, of quality, and more accessible. I found that there remains a need for culturally adapted mental healthcare interventions. Inconsistencies in mental healthcare treatments for young adult Latina women put them at a greater risk for continued mental healthcare issues (Cabeza de Baca et al., 2018). Not all young adult Latina women can communicate in English; therefore, this can create a barrier when they are trying to get mental health services (Shuey & Leventhal, 2018).

Although young adult Latina women are still limited in the knowledge of seeking out and engaging with mental healthcare resources, they should still be made readily available if the need ever arose. My study's findings reinforced the need to provide young adult Latina women with healthcare that is also more accessible to assist them with the mental health issues they are experiencing.

With the young adult Latina woman demonstrating a need for mental healthcare resources, policymakers and practitioners can use this information to change the standard of quality healthcare from only being accessible to some to incorporating anyone who needs mental healthcare resources (Chase & Rousseau, 2018). The findings of my research study could also be used to enlighten young adult Latina women who may be undecided about the need for seeking out mental health support, that they are not alone in their journey, and that there are supportive efforts being made to assist them.

The young adult Latina women had limited knowledge of mental healthcare resources when asked during their interview sessions. Providing young adult Latina women with more knowledge on mental healthcare resources could lead to more knowledge being shared across their families and communities. Expanding cultural competence among healthcare providers and policymakers is important to address the mental health challenges young adult Latina women are facing. Creating and providing culturally specific mental healthcare interventions, combining bilingual access to safety and quality of care, and encouraging connections inside their cultural community, are some of the ways to limit the obstacles faced by young adult Latina women in mental healthcare (Ramos-Sánchez, 2020).

Young adult Latina women, who seek out and use healthcare resources, could likely lessen the gap that remains in quality and the ability to access mental healthcare resources to increase their knowledge. The important implication for social change is mental healthcare resource engagement and how it could significantly affect a person's life. Young adult Latina women who decided to seek out and engage with mental

healthcare support could then begin to break free from the stigmatization of needing mental healthcare support (Chase & Rousseau, 2018). Young adult Latina women could then bring this knowledge on the necessity and benefits of mental healthcare intervention to others in their community (Iorfino et al., 2019). Another way to increase knowledge about mental healthcare could be by providing bilingual advocates in the Latino community.

Government programs could provide more information on the service areas for clients such as literature and advertisements on television monitors, as well as advertisements on public transportation in these communities. Information could also be shared through schools by way of parent-teacher associations. Automated calling or digital messaging could also be considered as ways to inform and get young adult Latina women engaged with mental healthcare resources (Iorfino et al., 2019). Overall, there could be an improvement in the quality and accessibility of mental healthcare supports for anyone who is experiencing mental health issues.

Conclusion

My qualitative phenomenological study contributed to the literature by discussing the gap in the literature on cultural interventions for young adult Latina women. My an understanding of how young adult Latina women viewed the disparities in the cultural competency, quality, and accessibility of mental healthcare resources was crucial for distinguishing what areas in mental healthcare resources required consideration for the mental healthcare needs of young adult Latina women. Young adult Latina women's acknowledgment of the necessity for mental healthcare resources could potentially

decrease the mental health issues they are experiencing and the stigma surrounding the need for seeking mental healthcare resources. Their acknowledgement could also assist with enlightening young adult people of color about mental healthcare, making it the focal point of mental stability, as opposed to the stigma surrounding the use of mental healthcare resources.

The young adult Latina women interviewed held meaningful perspectives on mental healthcare resources. Their viewpoint showed a need to provide support for them. During the data collection process, I also uncovered productive perceptions held by this group of young adult Latina women regarding seeking out and engaging with mental healthcare resources. In the end, the outcome I received from this research study is encouraging. My study's ability to increase cultural competency, quality, and accessibility of mental healthcare resources for young adult Latina women, who are suffering from limited resources, could only help to bring about positive outcomes for these women. Young adult Latina women's beliefs, values, language, and norms play a significant role in every aspect of their lives that affects receiving mental healthcare (Cabeza de Baca et al., 2018). Mental healthcare interventions that are culturally specific are very important to the mental health ability of young adult Latina women.

I discovered through my research and data collection is the issue with executing new initiatives in mental health is not due to a lack of use, it comes from a lack of knowledge and communication on how to follow through with providing the support. I believe mental healthcare resources can provide relief from mental health instability. I also found that mental healthcare initiatives, to provide healthcare support, are needed for

young adult Latina women who are experiencing mental health issues such as depression and anxiety. The development and implementation of culturally specific interventions can promote positive mental health outcomes for people suffering from mental health issues.

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Appendix A: Letter of Permission

Dear Mr. Carvajal,

I am a Ph.D. student at Walden University and am in the process of completing my dissertation. My research study requires the recruitment of participants to interview to gather data for the research study. The Human Resources Administration Agency provides a great opportunity to accomplish this because we service a wide variety of individuals and families. I am requesting permission to post recruitment flyers in the customer waiting for areas to recruit potential participants. Thank you in advance for your consideration.

Best regards, Cheryl Smith

Appendix B: Recruitment Flyer

The research study seeks participants seeking mental health support and participating in mental health services.

There is a new study called *"Exploring the Lived Experiences Involving Seeking and Engaging in Mental Health Supports of Young Adult Latina Women"* that could help care providers like doctors and counselors better understand and help their patients. For this study, you are invited to describe your experiences seeking and finding participating in mental health care.

This research study is part of the doctoral study for Cheryl Smith, a Ph.D. student at Walden University.

About the study:

- One 60-minute virtual interview
- To protect your privacy, no names will be collected.

Volunteers must meet these requirements:

- 18-35 years old
- History of seeking mental health services or support
- Latina descent

If you are interested, you can confidentially volunteer by emailing me at

Appendix *C:* Interview Questions

1. Tell me about the first time you came to the United States.
    a. How long have you lived in the US as a permanent resident?
2. How would you describe the experience of leaving your home country to become a new resident in the United States?
    a. Do you feel like it affected you positively or negatively?
    b. Did you move alone or with family?
3. Describe your experience of connecting with the new community.
    a. How would you describe the culture you are currently living in?
4. Describe the strategies that you used to help you get familiar with the new community you live in.
    a. What strategies did you use to find housing? Employment? Health Care?
5. Describe any challenges you faced in your new community.
6. Tell me about any challenges you faced when looking for health care resources.
7. Did you have any ideas of what would better help you with finding quality health care?
8. Tell me about your first experience in any health care facility.
    a. How did you find your health care provider?
    b. What was your first experience with your provider?
    c. How would you describe their demeanor toward you? What were the things that you liked? What were the things you did not like?

d. What are some of the characteristics that you look for from your health care provider?

9. What strategies did you use to look for health care resources?
    a. Did you learn of your health care provider/resource through the family? Internet? Friends? Referrals?
10. Did you have any ideas of what would better help you with finding quality health care?
        a. What are some challenges you faced in finding quality health care?
11. Do you have a sense of trust for health care providers outside of your culture?
        a. What are some of the things that you would like to receive from your health care provider?
12. Describe the barriers that you have overcome from being impacted by a new culture.
        a. Have you since encountered any new barriers?
13. How would you describe your experience as a Latina woman finding health care resources?
14. Please feel free to describe any thoughts that you think are important for me to know that you have not already shared.

Appendix D: Participant Resources

New York Project Hope 1 (844) 863-9314 - This site offers an emotional support helpline and other free services. Meetings can be done online or by phone. The site has group meetings that offer support that include emotional stress, grief, isolation, and loneliness. The meetings are confidential, anonymous, and free.
https://nyprojecthope.org/?utm_medium=G1Search&utm_source=Google&utm_campaign=OMHProjectHOPERSPGrant

National Alliance on Mental Illness - This site offers online discussion, a helpline that offers one on one support, and support groups to assist people with mental health conditions. Services are free and have a helpline for Spanish-speaking individuals 1 (800) 950-NAMI or text NAMI to 74174.
https://www.nami.org/Find-Your-Local-NAMI/Affiliate/Details?state=NY&local=0011Q000022G8FEQA0

Healthline - This site offers free online therapy to address mental health conditions. This is done via messaging app, telephone, or video chat. The site offers Spanish-speaking services.
https://www.healthline.com/health/mental-health/online-therapist-for-free

Strong 365 - This site offers free, confidential mental health support by licensed counselors who specialize in helping young adults sort out mental health concerns. The site offers Spanish-speaking services.
https://nywell.strong365.org/ally/faq/index.html

Documented - This site provides a list of organizations that provide free mental health services for immigrants in New York City.
https://documentedny.com/2020/12/12/mental-health-resources-for-immigrants-in-new-york/

Psych Central - This site offers free services including workshops and a directory of therapists, available in English and Spanish to discuss mental health topics affecting people of color in New York City.
https://psychcentral.com/health/mental-health-resources-for-people-of-color#list-of-resources