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College of Psychology and Community Services

This is to certify that the doctoral dissertation by

Kierra McShine-Gregory

has been found to be complete and satisfactory in all respects,
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the review committee have been made.

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Walden University
2022

Abstract

Consideration of Mindfulness Intervention for Hispanic Adolescents in a School Setting

by

Kierra McShine-Gregory

MA, Norfolk State University, 2011

BA, University of Maryland- Baltimore County, 2009

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Human Services: Crisis, Intervention, and Disaster

Walden University

December 2022

Abstract

Hispanic adolescents' accessibility to treatment options for depression is met with limitations associated with financial barriers and cultural misalignment. This research study aimed to bring to light an alternative psychotherapy treatment through the foundations of mindfulness interventions. The goal was to understand the experience of Hispanic adolescents when engaging in mindfulness in a school setting. The purpose of this study was to gather information about the experiences of Hispanic adolescents using mindfulness to support mental health practitioners, school counselors, and behavioral interventionists to provide treatment options that are accessible and meet the needs of this culture group. This explanatory case study focused on Hispanic adolescents ages 14-18 engaging in an 8-week school-based mindfulness intervention group. The data was collected through parents/guardian and teacher interviews, adolescent reflections, and archival documents provided by group facilitator. The data were analyzed using thematic and propositional analysis to answer "how" and "why" mindfulness may benefit Hispanic adolescents. This study showed that mindfulness played a vital role in the gradual increase in positive well-being for Hispanic adolescents over the 8 weeks. Furthermore, parents and teachers were positively impacted by their intentional focus on the adolescents during the 8 weeks. These findings indicate a positive outlook for continued research in understanding the perspectives of mindfulness for Hispanic adolescents with depression or depressive symptoms from a larger sample population, as well as understanding the perspective of mindfulness as a treatment option for other minority culture groups, specifically African Americans.

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Dedication

I dedicate my dissertation work to the people in my life who have impacted the foundation of who I am today and who continue to support my dreams. To my parents, Mark and Luxtracia your sacrifices and modeled persistence have motivated me to reach my highest potential. My sisters Tierra, Brenda and Marquita thank you for showering me with words or encouragement and affirmation throughout this process.

I also dedicate this dissertation to my wife, Kamilah. My original mindfulness advocate and teacher who showed me the foundations of mindfulness practices. You showed me something over 10 years ago that changed how I showed up in life and I am forever grateful. "I love you because the entire universe conspired to help me find you", and I thank the universe every day.

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I would like to acknowledge and thank the school associated with this study for allowing me to conduct my research and providing any assistance requested.

Finally, I would like to thank the parents, teachers, group facilitator and Hispanic youth that engaged in this study. Their willingness to engage fully made the completion of this research attainable.

Table of Contents

List of Tables v

List of Figures vi

Chapter 1: Introduction to the Study 1

Background of the Study 1

Problem Statement 2

Purpose 5

Significance 6

Theoretical Framework 6

Research Questions 7

Nature of Study 7

Unit of Analysis 8

Limitations, Challenges, and Barriers 9

Assumptions of the Study 11

Delimitations 12

Definitions of Key Terms 13

Summary 14

Chapter 2: Literature Review 15

Literature Search Strategy 15

Theoretical Framework 16

A Brief History of Mindfulness 18

The Origin of Mindfulness 19

Mindfulness in the West 20
Applications of Mindfulness in the Contemporary World 21
Mindfulness as a Therapeutic Intervention 23
Summary of Outcomes and Assumptions 27
A Brief History of Depression 29
In the Beginning 29
Enlighten Years (the 1700s–1900s) 30
Millennium Treatment for Depression 31
Adolescent Depression 33
Depression Among Adolescents in the United States 33
Depression Among Hispanic Adolescents in the United States 34
Treatment Barriers for Hispanic Adolescents with Depression 35
Mindfulness for Adolescents With Depression 37
Mindfulness as an Intervention for Adolescents 37
Mindfulness as an Intervention for Hispanic Adolescents 39
Summary and Conclusions 41
Chapter 3: Research Method 44
Research Design and Rationale 45
Research Question 45
Research Design 45
Role of the Researcher 47
Connection to Environment 47

Connection to the Study 48

Methodology 49

Unit of Analysis 49

Inclusion Criteria 50

Site Permission and Informed Consent 53

Data Collection 54

Data Analysis 61

Issues of Trustworthiness 65

Ethical Procedures 66

Semi-Structured Interviews 67

Archival Analysis: Student Reflective Notes 67

Archival Analysis: Facilitators Reflective Notes 68

Summary 69

Chapter 4: Results 70

Setting 71

Demographics 71

Data Collection 72

Data Analysis 73

Data Coding 74

World Cloud 75

NVIVO Software 86

Evidence of Trustworthiness 87

Summary 88
Chapter 5: Discussion 90
Introduction 90
Interpretation of the Findings 91
Mindfulness as an Intervention 92
Stakeholders Characterization (Parent and Teacher) 93
Participatory Characterization (Hispanic Adolescents) 95
Limitations of the Study 96
Recommendations 98
Parents and Teachers 98
Mental Health Professionals 99
Future Research Recommendations 100
Implications 100
Conclusion 102
References 103
Appendix A: Site Permission 122
Appendix B: Inclusion Criteria 123
Appendix C: Student Assent Form for Research 124
Appendix D: Demographic Survey 126
Appendix E: Semi-Structure Interview Questions (Parents/Teachers) 127
Appendix F: Youth Reflective Note 128
Appendix : Facilitators Reflection 131

List of Tables

Table 1. Unit of Analysis 15

Table 2. Inclusion Criteria 56

Table 3. Informed Consent 58

Table 4. Instrumentation 75

Table 5. Data Collection 75

Table 6. Weekly Sessions and Feelings Reflected Through Words 87

List of Figures

Figure 1. World Cloud – All Transcripts 78

Figure 2. Thematic Map – Mindfulness Outcome 83

Figure 3. Thematic Map – Expressed Feelings 85

Chapter 1: Introduction to the Study

Background of the Study

Hispanics represent a large and rapidly increasing percentage of the United States population, accounting for approximately 15% of the U.S. population. According to the U.S. Census Bureau (2002), this figure has the likelihood to increase to 30% by the year 2050 (McCord, 2017; U.S. Census Bureau 2002;). However, despite the significant number of Hispanics in the United States, Hispanics' use of mental health services shows underrepresentation (McCord, 2017; Motjtabaii et al., 2016). In 2016, 10.6% of adolescents were affected by depression, with 10.8% of Hispanics experiencing depressive symptoms (Kroning & Kroning, 2016; Naicker et al., 2013; Werner-Seidler et al., 2017). However, Hispanics are less likely than non-Hispanic Whites to be involved in preventative and ambulatory health care services (Cho et al., 2014; Fergusson & Woodward, 2002; Vaughn-Coaxum, 2016). The disparity between the need for health services for Hispanics and the use of such services calls for an increased understanding of culturally relevant interventions, as well as themes associated with barriers to accessibility and increased utilization (Bridges et al., 2012; Chou et al., 2013; McCord, 2017; Vaughn-Coaxum, 2016). The utilization of health services by the Hispanic community members may be influenced negatively due to the challenges associated with accessing mental health treatment, including appropriate health insurance coverage, high poverty rates, immigration status, English fluency, social stigma regarding mental illness, and mental health treatment, and accessibility to culturally competent service providers (Cho et al., 2014; Motjtabaii et al., 2016). These factors may contribute to Hispanics'

underuse of mental health services, specifically adolescents. The low utilization calls for an increased understanding of adequate mental health services that target and meets the needs of Hispanic adolescents with depression or depressive symptoms (Bridges et al., 2012; Cho et al., 2014; Motjtabaii et al., 2016). Therefore, an explanatory case study was conducted to corroborate aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms. This chapter provides an overview of the significance, framework, nature of the study, data, limitations, delimitations, operations, and definitions.

Problem Statement

In 2016, depression affected 10.7% of adolescents (Kroning & Kroning, 2016; Werner-Seidler et al., 2017), with 9.0% of the U.S. population aged 12-17 experiencing at least one major depressive episode before reaching the age of 18 (Kroning & Kroning, 2016; Naicker et al., 2013; Vanghn-Coaxum, 2016). Also, minority groups experienced depressive symptoms at a higher rate than Whites, with 10.8% of Hispanic, 8.9% of African American, , and 7.8% of White youth reporting symptoms of depression (Fergusson & Woodward, 2002; Vaughn-Coaxum, 2016). Furthermore, accessibility to treatment typically corresponds with high medical costs, including medication, therapy, nutrition, classes, and educational resources (Fergusson &Woodward, 2002; Vaughn-Coaxum, 2016). However, if left untreated or undertreated, depression may lead to outcomes including mental disorders, suicidal behaviors, educational underachievement, unemployment, and early parenthood (Egede et al., 2016).

In 2016, the Hispanic population represented 17.8% or 57.5 million of the U.S.

population (Le et al., 2008; U.S. Census Bureau, 2002). Additionally, from 2005 to 2015, depression among Hispanic adolescents between the ages of 12-18 (Huq et al., 2016; Mojtabai et al., 2016) indicated that 46.7% of Hispanics reported feelings of sadness or hopelessness compared to 37.9% of Whites and 33.9% of African Americans (McCord, 2017; Vanghn-Coaxum, 2016).

In the late 1970s, Kabat-Zinn (1990) introduced the foundations of mindfulness to the clinical setting with a stress reduction program known as mindfulness-based stress reduction (MBSR). The program's goal was to determine if mindfulness lowered stress and enhanced the overall well-being of patients with chronic pain over eight weeks (Huq et al., 2016; Khoury et al., 2012; Rubens et al., 2018). Mindfulness practices such as meditation, scanning, and reflection aided in positive outcomes for individuals, including decreasing stress and increasing emotional regulation and self-control (Khoury et al., 2012). However, research typically included an adult population, with limited findings on the outcomes of mindfulness interventions (MI) on adolescents, especially those from a Hispanic background (Burke, 2009; Segal, 2012).

Traditional treatments such as prescribed antidepressants, cognitive-behavioral therapy (CBT), and psychological counseling exist for adolescents (DeRubeis et al., 2008; Ford-Paz et al., 2013; Huq, 2016). However, accessibility to these treatments presents challenges for Hispanic adolescents due to limited time to seek services, costs for services, and difficulties with transportation (Ford-Paz et al., 2013; Francisco et al., 2018; Huq, 2016). Psychotherapy alternatives such as MI support individuals seeking treatment to reduce symptoms of depression and provide long-term benefits, including

the ability to manage independently with little cost to practice (De Vibe et al., 2012; Edenfield; Gouda, 2016). Furthermore, a therapist using MI supports individuals' emotional and cognitive stability (Khoury et al., 2012; Segal et al., 2012) with improvements in sleep, self-esteem, self-regulation, and awareness (De Vibe et al., 2012). Mindfulness intervention practices increased in the United States between 1970-2000; however, participants have been primarily White, female, and middle-to-upper-middle class (De Vibe et al., 2012; Khoury et al., 2013; Park et al., 2015; Segal, 2012;). People who participated in mindfulness intervention improved in managing stress and anxiety (De Vibe et al., 2012; Khoury et al., 2013). However, there have been limited findings associated with the overall experience of Hispanic adolescents with depression engaging in MI to decrease depressive symptoms (Fergusson & Woodward, 2002; Fung et al., 2016; Khoury et al., 2013; Schonert-Reichl & Lawlor, 2010; Segal, 2012). Thus, an explanatory case study was conducted to explain the experiences and understand how Hispanic adolescents with depressive symptoms engage in MI as an alternative to a traditional psychotherapy treatment (Khoury et al., 2012; Schonert-Reichl & Lawlor, 2010). Understanding the characterizations of mindfulness as an intervention to support Hispanic adolescents with depressive symptoms may be helpful for mental health practitioners when developing prevention, treatment, and rehabilitation services. Adolescent specialists and community organization staff, such as behavioral health services, may find the results of this study useful for clients as an alternative treatment for depressive symptoms (De Vibe et al., 2012; Gouda et al., 2016; Khoury et al., 2013).

Purpose

This explanatory case study was conducted to corroborate aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents, ages 14 – 18 with depressive symptoms. Using semi-structed interviews and reflection notes for this case study was essential for gaining an understanding of participant's experiences, beliefs, and the meanings associated with their collective views about mindfulness (Creswell & Poth, 2018; Kabat-Zinn, 1990; Young et al., 2018). The Mindfulness group facilitator utilized a structured checklist to capture weekly reflections in a classroom setting while facilitating the school-based mindfulness classroom activities. The facilitator guided students through mindfulness-based activities and individual reflections once a week for 8 weeks, lasting for no more than 1 hour. The facilitator's reflection was captured using a structure for weekly note taking (Appendix G) to collect data during the sessions and used later for analysis.

Understanding the experiences of Hispanic adolescents using MI may be helpful to mental health practitioners, school counselors, and behavioral interventionists who work with Hispanic adolescents with depressive symptoms to develop self-guided interventions for this population. This study includes information that readers may use to promote social change and fill a gap in the literature by providing relevant information that would be helpful when considering the implementation of MI as a tool for coping with depressive symptoms with Hispanic adolescents (Edwards et al., 2014; Xinli et al., 2018).

Significance

This explanatory case study may be helpful to mental health practitioners as a tool to inform as a first step in understanding how MI emerge for Hispanic adolescents with depression or depressive symptoms. Practitioners, including mental health professionals, school counselors, and behavioral interventionists, may strengthen the use of alternative psychotherapy treatment to mitigate the treatment gap for adolescents in urban communities (Khoury et al., 2012; Schonert-Reichl & Lawlor, 2010.) The study results may be helpful for mental health practitioners when developing prevention, interventions, and rehabilitation services, possibly strengthening the implementation of mindfulness as an alternative intervention for adolescents with depression or depressive symptoms.

Theoretical Framework

Kabat-Zinn's (1990) theory of MBSR and mindfulness practices serves as the theoretical framework for this explanatory case study. Mindfulness derived from Eastern meditation practices and Buddhist philosophy, referring to "bringing one's attention to the present experience" (Kabat-Zinn, 1990, p.437). Mindfulness can be associated with several psychotherapy interventions, including MBSR, mindfulness-based cognitive therapy, and behavior therapy (Ramel et al., 2004). Mindfulness-based intervention supports an individual's ability to pay attention to present emotions and tasks while eliminating worry and doubt imbedded in either the past or future, in hopes to promote inner peace and happiness (De Vibe et al., 2012). Kabat-Zinn's original purpose for MBSR was to help patients with physical illness deal with pain, stress, and negative emotions in behavioral medicine settings. However, since the 1970s, mindfulness

practices have been used in the general population for stress, anxiety, and depression (Virgili, 2015).

Engaging in MI using the MBSR framework may help individuals calm their mind and body, improve in life, and enhance self-capability to cope with various stressful situations (Brown & Ryan, 2003; De Vibe et al., 2012; Ramel et al., 2004). Therefore, this explanatory case study examines mindfulness practices to corroborate aspects of the practice of mindfulness as a treatment tool for Hispanic adolescents with depressive symptoms.

Research Questions

The following interrogatives are guides to this study:

1. How do stakeholders characterize MI for Hispanic adolescents, ages 14- 18 with depression or depressive symptoms in urban settings?
2. Do participatory characterizations corroborate, extend, and/or dispute mindfulness as an alternative psychotherapy treatment tool for Hispanic adolescents with depression or depressive symptoms in urban settings?

Nature of Study

An explanatory case study approach is a way for investigators to take an in-depth exploration of real-life phenomena (Yin, 2013). For this explanatory, single-case study, I answered *how* and *why* implementing mindfulness practices may be an essential alternative psychotherapy intervention for adolescents with depressive symptoms. The use of an explanatory case study design enabled me to explore and corroborate the real-life experiences of Hispanic adolescents with depressive symptoms engaging in MI in

urban settings in the Southern United States (Khoury et al., 2012; Schonert-Reichl & Lawlor, 2010;).

Unit of Analysis

The unit of analysis is from a single urban high school located in the Southern U.S. community. The high school is a public school, comprised of 98% Hispanic youth. I collected reflections from Hispanic youth ages 14 – 18 with depression or depressive symptoms within the mindfulness group. For this study, approved site permission from the authorized school administrator gave me access to begin to collect data for Hispanic adolescents identified as depressed or having depressive symptoms between ages 14 and 18 using a convenience sample. The unit of analysis included (a) mindfulness group facilitator, (b) parent/guardian of Hispanic youth, (c) teacher of Hispanic youth, and (d) Hispanic youth with depressive symptoms, who engaged in the mindfulness group for the length of program intervention (Monshat et al., 2013; Thomson et al., 2017). Understanding the experiences of a Hispanic adolescent on the spectrum for depression engaging in MI may provide helpful information for mental health practitioners, school counselors, and behavioral interventions when developing prevention treatment and rehabilitation for adolescents with depression or depressive symptoms. See Table 1.

Table 1

Unit of Analysis

Participants	Collection method	Rationale

Teacher of Hispanic youth	Semi-structured interview	Gain a deeper understanding of the teacher's feedback on student engagement in the mindfulness group.
Parent/guardian of Hispanic youth	Semi-structured interview	Gather descriptive insights, explanations, and meanings relating to youth's home life during engagement in the mindfulness group.
Group facilitator and administrator	Structured checklist & archival analysis	Gain an understanding of participants receptiveness to mindfulness as an Intervention
Hispanic youth with depressive symptoms	Individual reflection notes	Collect beliefs and sense of meaning about mindfulness Group

Note. Edwards et al., 2014; Yin, 2013 Young et al., 2018

Limitations, Challenges, and Barriers

For this explanatory case study, four Hispanic adolescents, one teacher of Hispanic adolescent, and one parent/guardian of Hispanic adolescent were the identified participants in the study. I corroborated aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents, ages 14 – 18, with depressive symptoms. A limitation to consider was associated with the perceived outcome of the mindfulness model (Yin, 2013). This case study's purpose was not to determine the effectiveness of the mindfulness model, but rather provide understanding associated with the theory of the mindfulness model, describing how the model worked and why the model worked with this specific population (Woolcock, 2013; Yin, 2013). This case study did not represent an optimal way to provide mindfulness as an intervention for program effectiveness and cannot be generalized beyond analytical value (Yin, 2013). The methodology structure of

this study, using several forms of data collection types including semi-structed surveys, archival analysis, and reflective notes inherently mitigated the generalizability through triangulation of the data collection. Therefore, the managing and organization of the data collection was essential to supporting a clear and systematic review of findings. Using thematic analysis to produce study trends supported concise findings within the unit of analysis (Evans & Lewis, 2018; Nikitas et al., 2019). Continuous reevaluation of data collected responses through triangulation and thematic trends across unit of analysis supported the transferability of the study findings (Yin, 2013) and limited assumptions and skewed favor when interpreting data collection (Bowen, 2009; Evans & Lewis, 2018).

Biases may be present in the study in relation to the researcher and participants (Van der Gucht et al., 2019; Yin, 2013). A researcher bias that is pervasive is confirmation bias, which occurs when a researcher forms a hypothesis or belief and uses respondents' information to confirm that belief (Yin, 2013). As a researcher with experience in the community and mindfulness, it was essential to minimize confirmation bias. Therefore, constant reevaluating through participants' written responses, interviewers' recorded responses, and participants' review of facilitators' reflective notes supported in minimizing confirmation bias ((Bowen, 2009; Evans & Lewis, 2018; Monshat et al., 2013; Yin, 2013). The inherited power that may have been prevalent as a leader on campus may cause parent/guardian, teacher, or student responses to lean in favor of an affirmative when responding to researcher questioning (Bowen, 2009; Evans & Lewis, 2018; Monshat et al., 2013). Therefore, I targeted participant bias by not asking

questions directly that would employee participants to be in my favor. Posing questions to teacher and parent/guardian supported participants engagement and direct interaction with MI through written/audio recorded responses. I was not present during mindfulness group facilitation. Therefore, comparison of participants reflective notes with facilitators' reflective supported participants; bias throughout the study (Bowen, 2009; Evans & Lewis, 2018; Monshat et al., 2013).

Assumptions of the Study

For this study, I believed that participants would provide honest views about their experience in engaging in mindfulness. Previous research using mindfulness as a methodology reported that participants who engaged in MI described their experience as a supportive environment (Hughes et al., 2017; Thomas et al., 2017; Young et al., 2018). Participants felt a sense of trust and comfortability when meeting with others who shared similar attributes (Hughes et al., 2017; Thomas et al., 2017; Young et al., 2018).

I used interviews, document analysis, and reflections to collect data. The interview questions for teachers and parent/guardians were clear and helpful for eliciting their shared experiences. Semi-structured interviews served as an appropriate instrument when those being questioned had a low level of awareness of the subject or the phenomenon being addressed, which presented levels of comfortability during the discussion (Evans & Lewis, 2018; Hyett et al., 2014). Therefore, the questions created a fluid dialogue between stakeholder and researcher, which supported in maximizing clarity of responses. Audio recording the interviews supported a smooth data collection process when speaking with teacher and parent/guardian. The support of the interview

being recorded and transcribed by the audio tool Otter aligned in capturing the trends for data analysis of teacher and parent/guardian shared experience (Evans & Lewis, 2018; Hyett et al., 2014).

Additionally, archival analysis (grades, behavior, administrative report) was subjective to selective information pulled for review. I was not a school staff member; therefore, the archival analysis that was pulled was secondary retrieval and limited to what was provided by the school administrative. However, having multiple forms of data collection supported the holistic view of the Hispanic youth participating in the study and not just relying on one piece of data to analysis.

Lastly, reflective notes and structured checklist presented aligned trends that captured the elicit meaning, understanding, and empirical knowledge being displayed by study participants (Bowen, 2009; Creswell & Poth, 2018). I anticipated that participants shared insight that was not aligned with the overall narrative of the study as evident by participants' independent reflective notes possibly capturing unrelated narratives. However, having that contextual information supported additional understanding of trends associated with the study (Bowen, 2009; Creswell & Poth, 2018). To support in capturing aligned trends, the youth reflective notes and facilitators checklist were reviewed with participants at the end of the 8-weeks to support in the final alignment and validity of the findings.

Delimitations

In general, this study focused on mindfulness as an intervention model for Hispanic adolescents with depressive symptoms. The study participants were 14-18 years

of age from a single high school in urban Southern United States, comprising 98% Hispanic youth. The school environment presented inclusivity to the sample's targeted demographic, age, and ethnicity. The selected delimitations were the basis of how and why implementing mindfulness practices may be an essential alternative psychotherapy intervention for adolescents with depressive symptoms (Van der Gucht et al., 2019). The chosen participants' experience hopefully offers insight for mental health practitioners when developing prevention, interventions, and rehabilitation services, possibly strengthening the implementation of mindfulness as an alternative intervention for adolescents with depression or depressive symptoms.

Definitions of Key Terms

Depression: a mood disorder that causes a persistent feeling of sadness and loss of interest. Depression affects how you feel, think, and behave and can lead to a variety of emotional and physical issues *(*Motjtabaii et al., 2016)

Depressive symptoms: symptoms of depression may include sadness, hopelessness, angry outburst, irritability or frustration, sleep disturbances, lack of energy, reduced appetite, weight loss, trouble concentrating, suicidal thoughts, and unexplained pain or headaches (Motjtabaii et al., 2016).

Hispanic: a person living in the United States of Latin American descent (McCord, 2017).

Mindfulness: The contemporary definition of mindfulness is "paying attention on purpose, in the present moment, and nonjudgmentally "(Kabat-Zinn, 1990,

p.437).Mindfulness embodies noticing thoughts and emotions as they enter the mind but letting them pass through without reacting emotionally or physically (Kabat-Zinn, 2003).

Mindfulness intervention: practices used to support the idea of “paying attention on purpose,” including body scan, journaling, meditation, yoga, walking meditation stretching, music, and art play (Khoury et al., 2012)

Summary

I conducted an explanatory case study to corroborate aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms. Chapter 1 included introductory information about the research. Chapter 2 contains a literature review, including the literature search, history, and essential information relating to the empirical data about mindfulness, mindfulness as an intervention, treating depression with mindfulness, and mindfulness usage amongst culture groups.

Chapter 2: Literature Review

The purpose of this explanatory case study was to corroborate aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms. The reviews include information relating to the empirical data about mindfulness, mindfulness as an intervention, treating depression with mindfulness, and mindfulness usage amongst culture groups (Gouda et al., 2016). In reviewing multiple studies written on mindfulness, literature about mindfulness in conjunction with depression amongst Hispanic adolescents is relevant to this research (De Vibe et al., 2012; Edenfield & Saeed, 2012; Edwards et al., 2014; Mojtabaii et al., 2016).

Literature Search Strategy

I obtained information in this review from the following databases: PsychINFO, PsychArticles, PubMed, and Medline Internet databases as resources to build the study's foundation or relatable literature. The review also contains information from additional sources, including Internet sources from governmental organizations. I located over 200 related articles by using the following keywords to obtain dissertation related topics: Kabat-Zinn, mindfulness, MBSR, MIs, adolescent depression, mindfulness for adolescents with depression, mindfulness with Hispanic adolescents, history of mindfulness, mindfulness in schools, mindfulness, and mental health. A historical summary of mindfulness for Hispanic adolescents with depression is integral to the literature review.

The literature reviewed in this chapter includes the historical background of mindfulness and examples of mindfulness treatment options for adolescents treating

depression (Gouda et al., 2016; Khoury et al., 2013). A review of the literature includes a brief understanding of the evolution of mindfulness in the western culture and the incorporation of mindfulness as a psychotherapy intervention for adolescents, and the associated impact on adolescents using mindfulness as an intervention tool (Edwards et al., 2014; Schonert-Reichl & Lawlor, 2010). A study on mindfulness might provide insight into the lived experiences of Hispanic adolescents using alternative interventions to cope with depression (Khoury et al., 2013; Schonert-Reichl & Lawlor, 2010). This literature review chapter includes the following: (a) literature search strategy; (b) theoretical framework; (c) brief history of mindfulness; (d) brief history of depression; (e) adolescent depression; and (f) mindfulness for adolescents with depression.

Theoretical Framework

For this explanatory case study, the theory of mindfulness served as the theoretical framework. A vast majority of articles on mindfulness using adolescents cited Kabat-Zinn (1990) when defining mindfulness (Chi et al., 2018; De Vibe et al., 2012; Gouda et al., 2016; Mojtabaii et al., 2016; Thomson et al., 2017; Van der Gucht et al., 2019; Virgili, 2015). Kabat-Zinn defines mindfulness as an experience that involves an individual "paying attention in a particular way, on purpose, in the present moment, and non-judgmentally" (Chi et al., 2018; Huq et al., 2016; Kabat-Zinn, 1990; Khoury et al., 2013; Rubens et al., 2018). Entering the state of mindfulness involves shifting to an alternative perspective that allows for a clearer picture of one's current experience to understand better things that are not always concrete (Langer & Moldoveanu, 2000). Metacognitive awareness is an essential component of mindfulness that fosters an

individual's ability to be aware of how one is thinking and the strategies one is using to assess their state of being (DeRubeis et al., 2008; Ford-Paz et al., 2015; Huq et al., 2016; Kabat-Zinn, 2003), thereby enabling individuals to focus on what they are doing, why, and how the skills they are using may be applicable in all situations (Brown & Ryan, 2003; Chi et al., 2018; Gouda et al., 2016; Kabat-Zinn, 1990).

Mindfulness offers individuals an opportunity to practice being in a state of consciousness where they no longer control their thoughts, emotions, or bodily sensations. Mindfulness aims to support individuals in realizing that while their thoughts, emotions, and feelings exist, they do not have to incapsulate them (Ford-Paz et al., 2015; Rubens et al., 2018; Van der Guht et al., 2019; Virgili, 2015). Practicing mindfulness consistently supports individuals to take a pause regularly to reflect and adjust (DeRubeis et al., 2008; Ford-Paz et al., 2015; Huq et al., 2016). Recognition and purposeful processing of one's thoughts may allow for separation of immediacy when assessing thoughts and actions (Chi et al., 2018; Gouda et al., 2016; Kabat-Zinn, 2003). When considering the underserved population of Hispanic adolescents at risk for depression, it is essential to understand their real-life experiences using MI as a treatment option (Ford-Paz et al., 2015; Francisco et al., 2018; Huq et al., 2016).

Research has shown that mindfulness-based treatment interventions may be useful for a range of mental and physical health disorders in adult populations, but little is known about the effectiveness of such interventions for treating adolescent conditions (Burke, 2010; DeRubeis et al., 2008; Ford-Paz et al., 2015; Huq et al., 2016; Segal et al., 2012). MIs are on the brink of exploration for psychotherapy treatment in Western

culture (Bishop et al., 2004; Kabat-Zinn, 1982). Researchers who seek to replicate, while holding to the founding principles and practices aligned to Kabat-Zinn's original approach, have resulted in positive outcomes (Chi et al., 2018; Fung et al., 2016; Gouda et al., 2016; Kabat-Zinn, 1990, 2003; Therefore, I sought to provide descriptive data to add essential information to the field of practice by providing relevant information that would be helpful when considering the implementation of MIs as a tool for coping with depressive symptoms with Hispanic adolescents (De Vibe et al., 2012; Gouda et al., 2016; Khoury et al., 2013). This literature review reviews the following: (a) brief history of mindfulness; (b) brief history of depression; (c) adolescent depression; and (d) mindfulness for adolescents with depression.

A Brief History of Mindfulness

The origins of mindfulness stem from Buddhist meditative traditions for being present (Gouda et al., 2016; Kabat-Zinn , 1990, 1994). Buddhists believe that mindfulness helps to relieve suffering through knowing, shaping, and liberating the mind (Kabat-Zinn , 1990, 1994). Nonetheless, Buddhist is not the only culture connected to mindfulness (Gouda et al., 2016; Kabat-Zinn, 1994; Keng et al., 2011). Mindfulness is a core concept shared with many traditions and philosophies such as the yogic traditions, Greek philosophy, Christianity, and modern-day works on spiritual enlightenment (Keng et al., 2011). The word mindfulness originally comes from the Pali word *sati*, meaning having awareness, attention, and remembering (Bodhi, 2004).

Mindfulness is correlated to a "process" instead of a series of meditation practices (Bishop et al., 2004; Monteiro et al., 2014). Mindfulness aims to create intentionality

with the present moment, exclusive of time, and present of relaxation around the frenetic pace of routine activities (De Vibe et al., 2012; Gouda et al., 2016; Chi et al., 2018). Mindfulness core foundation uses meditation to cultivate, focusing on the breath (Gouda et al., 2016; Kabat-Zinn, 2003). Breath movement supports are natural human instincts associated with mind-wandering (Kabat-Zinn, 2003; Park et al., 2015). Since the onset, Mindfulness has continued to evolve in mainstream clinical and nonclinical settings as a beneficial therapeutic intervention to combat stress, anxiety, depression, and chronic (Chi et al., 2018). This section highlights the origins of mindfulness, Mindfulness in the Western culture, and current mindfulness practices in 2020.

The Origin of Mindfulness

The Eastern culture has 2,500 years of connection to mindfulness for personal development, spiritual growth, and medical intervention (Kabat-Zinn , 1990; Ludwig & Kabat-Zinn, 2008). In the 1970s, others began using the term “mindfulness” to systematically apply mindful awareness in Western (Kabat-Zinn , 1990). Between 1970 and 2020, Mindfulness has evolved from a relatively unknown Buddhist meditation practice to mainstream medicine, health care, and the broader society (Bishop et al., 2004; Kabat-Zinn, 1982). In the West, Mindfulness was popularized in health settings by Kabat-Zinn (1990) at Massachusetts’ Medical School. Kabat-Zinn’s work introduced western culture to Mindfulness and the wellness idea that mindfulness is not primarily an allopathic or naturopathic cure but a way to face and embrace symptoms and illness (Dryden & Still, 2006; Segal et al., 2012). Mindfulness has played a part in Western culture since the early 1970s with the onset of Kabat-Zinn’s (1994) 8-week group

intervention known as MBSR (Kabat-Zinn, 1994). MBSR supports individuals in learning techniques associated with mindfulness to enhance awareness of the present moment (Bishop et al., 2004; Hölzelet al., 2011; Kabat-Zinn, 2003; Ludwig & Kabat-Zinn, 2008).

Mindfulness in the West

The modern concept of mindfulness emphasizes "paying attention in a particular way: on purpose, in the present moment, and non-judgmentally" (Kabat-Zinn, 1994). Mindfulness is showing an appreciation for an experience by connecting intentionally with care and discernment (Kabat-Zinn, 1994). The westernized programming for mindfulness is MBSR (Kabat-Zinn, 1994). Development took place in the late 1970s as an 8-week group intervention for people experiencing a range of medical problems, including chronic pain, within a university-based medical center (Kabat Zinn , 1990). The MBSR core curriculum was later incorporated into mindfulness-based cognitive therapy (MBCT) to prevent relapse in adults with previous depression (Segal et al., 2012). MBSR and MBCT include a series of mindfulness meditation practices drawn from Buddhist origins applied in a secular context, offering universal applications not tied to religious or philosophical traditions (Baer, 2005; Dryden & Still, 2006; Kabat-Zinn, 1990). Although mindfulness-based intervention usage has been around for over 20 years, in the last 10 years, more researchers have been examining the psychological construct of mindfulness to establish consensus on the operational definition, elements, and processes (Bishop et al., 2004). Research has shown Mindfulness to be effective in the treatment of anxiety disorders (Semple et al., 2005), depression (Schonert-Reichl & Lawlor, 2010), borderline

personality disorder (Chapman , 2006; Fournier et al., 2010), addiction (Bowen et al., 2007), and eating disorders (Baer et al., 2005; Kristeller et al., 2006).

Applications of Mindfulness in the Contemporary World

Mindfulness has outlined many benefits, and researchers have developed numerous evidence-based psychotherapy treatments that incorporate mindfulness as a learned skill, including mindfulness-based stress reduction (Gouda et al., 2016), dialectical behavior therapy (Jennings & Apsche, 2014), acceptance and commitment therapy, and MBCT (Park et al., 2015), that all use exercises and practices to develop mindfulness skills (Gouda et al., 2016; Park et al., 2015; Chi et al., 2018). Treatment options incorporating mindfulness as a foundational skill are attempting to build a sense of awareness and understanding of their client's physiological and psychological experiences (Gouda et al., 2016).

With its origins in Buddhist practices, contemporary mindfulness is being used in secular health care and general wellness (Monteiro et al., 2014). When referencing in this review, the term "contemporary" refers to the adapted form of mindfulness derived from the Buddhist philosophy and transformed by the Western culture (Monteiro et al., 2014). Contemporary uses of Mindfulness-based interventions show positive outcomes in adults who suffer from depression, stress, pain, and illness (Mojtabaii et al., 2016; Monteiro et al., 2014). However, research on the outcomes of mindfulness with adolescents is not as widespread as work with adults (De Vibe et al., 2012; Park et al., 2015). However, in the last decade, there has been growing research, with studies taking place in schools and clinical settings (Werner-Seidler et al., 2017).

In 2014, Bluth et al. (2016) conducted a study in an alternative high school in North Carolina for 33 students in grades 9th -12th-grade serving high-risk adolescents (54% Hispanic, 24% African American, 18% White) who were struggling academically within the traditional public high school (Bluth et al., 2016). Bluth and colleagues used the MI "learning to BREATHE" curriculum to teach mindfulness skills, including body scan, sitting meditation, lovingkindness practice, walking meditation, and mindful movement (Bluth et al., 2016). The results showed a statistically significant difference in students with depression and a change in scores in the area of anxiety, suggesting the MI group decreased anxiety (Bluth et al., 2016).

Young et al. (2018) conducted a randomized controlled trial testing a 5-week mindfulness-based intervention known as TAM (Taking the Adolescent Mind) with seven youth aged 13 to 17 years receiving outpatient psychiatric treatment for mental health disorders. Participants engage in activities, including drawing, listening to music, eating, sculpting, and 10 minutes daily home practice (Young et al., 2018). This study tested the feasibility of TAM with a group of underserved adolescents at risk for depression based on elevated perceived stress and brooding tendencies (Young et al., 2018). Quantitative findings showed a sustained positive impact on self-esteem, perceived stress, and depressive symptoms in this sample of Hispanic/Latino, economically disadvantaged adolescents (Young et al., 2018). These findings suggested that underserved, high-risk youth may benefit from mindfulness-based intervention (Young et al., 2018).

Amongst the research, MI studies with adolescents show feasibility and promising

outcomes as interventions are typically acceptable and well-liked by participants (Burke, 2009; Hughes et al., 2017; Thomson et al., 2017). The consensus is that adolescents enjoy and appreciate mindfulness courses and that the outcomes associated with adolescents are similar to the positive change's observable in adults (Mojtabaii et al., 2016; Monteiro et al., 2014).

Mindfulness as a Therapeutic Intervention

Mindfulness as a therapeutic intervention supports the treatment of various disorders, whether a clinical application or personal application (Chi et al., 2018). Currently, four evidence-based psychotherapy treatments incorporate mindfulness as a learned skill, including MBSR (Gouda et al., 2016), dialectical behavior therapy (Jennings & Apsche, 2014), acceptance and commitment therapy, and MBCT (Park et al., 2015).

Mindfulness-Based Stress Reduction (MBSR)

The MBSR program introduced the clinical incorporation of mindfulness to the western world in the 1970s as an approach to treating patients struggling with life stressors and physical and mental illnesses (Huq et al., 2016; Kabat-Zinn, 2003; Khoury et al., 2013; Rubens et al., 2018;). MBSR is a flexible and customizable approach to stress reduction, composed of two main components: mindfulness meditation and yoga (Kabat-Zinn, 2003; Park et al., 2015; Chi et al., 2018). The program's approach is not based on a structured script or following a step-by-step process; Mindfulness is practiced in the manner that best suits the individual (Ford-Paz et al., 2015; Kabat-Zinn, 2003). Using the original elements of MBSR, with customization for your intended population,

provides an intentional framework that helps practitioners monitor the success of mindfulness for their targeted population (Gouda et al., 2016; Kabat-Zinn, 2003; Chi et al., 2018). Mindfulness exercises under the umbrella of MBSR, with practices infused to support participants application of body awareness, including meditative breathwork through body scans, sensory awareness in mindful eating, awareness of space through walking meditation, as well as physical awareness through stretching and yoga (De Vibe et al., 2012; Gouda et al., 2016; Kabat-Zinn, 2003; Chi et al., 2018). MBSR utilizes these practices to support individuals with anxiety, depression, chronic pain, stress, anger, ADHD, and sleep problems (De Vibe et al., 2012; Kabat-Zinn, 2003; Park et al., 2015).

Dialectical Behavior Therapy

In the 1980s, Marsha Linehan developed Dialectical Behavior Therapy to treat people with borderline personality disorder (Jennings & Apsche, 2014). However, research shows that DBT successfully treats people experiencing depression, eating disorders, bipolar disorder, post-traumatic stress disorder, substance abuse, and any other conditions that involve dysfunctional emotional regulation (Chapman A. L, 2006; Clive et al., 2004). DBT skills support individuals who struggle with regulating emotions, coping with distress, and negative emotions (Chapman A. L, 2006; Clive et al., 2004). DBT skills utilize individual therapy sessions and skills groups to supports individuals in developing mindfulness skills that encourage them to form non-judgmental mindsets when sharing and communicating with others (Harvey et al., 2019; Chapman, 2006). DBT focuses on helping individuals address dysfunctional thinking and behavior by modifying their thought patterns by changing their thoughts and behaviors (Harvey et al.,

2019; Jennings & Apsche, 2014). Individual weekly sessions provide an opportunity for the therapist and client to address issues and salutations that have come to surface throughout the week (Harvey et al., 2019; Jennings & Apsche, 2014). While weekly group sessions focus on developing skills in one of these four areas: Interpersonal effectiveness, distress tolerance, emotional regulation, mindfulness skills (Harvey et al., 2019; Jennings & Apsche, 2014). Group participants learn and practice skills alongside others; members of the group are encouraged to share their experiences and provide mutual support (Clive et al., 2004). DBT supports participants in building their mindfulness skills through their ability to observe, describe and speak from a non-judgmental lens (Clive et al., 2004; Jennings & Apsche, 2014), supporting their efforts to stay in the present moment and effectively communicate with others.

Acceptance and Commitment Therapy (ACT)

In the 1990s, Steven Hayes and colleagues developed another mindfulness system known as Acceptance and Commitment Therapy (ACT) (Park et al., 2015). ACT theorizes that greater well-being is obtained by overcoming negative thoughts and feelings (Hughes et al., 2017; Park et al., 2015; Ruiz, 2010). ACT focuses on assessing your character traits and behaviors to aid you in reducing avoidant coping styles (Park et al., 2015). ACT also addresses your commitment to making changes and what to do about it when you can't stick to your goals (Park et al., 2015; Ruiz, 2010). Therefore, an underlying foundation is that distress results from avoidance and fear (Blackledge & Hayes, 2001; Park et al., 2015). The acronym "ACT" stands for three focus areas: (1) Accept your reactions and be present-focused, (2) Choose a valued direction, and (3)

Take action. With the support of a therapist, individuals learn to focus on their self-talk, especially the self-talk associated with a traumatic event, problematic relationships, physical limitations, or other self-doubting thoughts (Coyne et al., 2011; Park et al., 2015; Ruiz, 2010). ACT theorizes that supporting individuals to take the necessary steps to change their behaviors while learning to accept their psychological experience supports that person in changing their attitude and emotional state (Coyne et al., 2011; Park et al., 2015; Ruiz, 2010). ACT supports individuals treating workplace stress, test anxiety, social anxiety disorder, depression, obsessive-compulsive disorder, and psychosis (Park et al., 2015; Ruiz, 2010) as well as medical conditions such as chronic pain, substance abuse, and diabetes (Coyne et al., 2011; Hughes et al., 2017; Ruiz, 2010). Mindfulness supports ACT through the meditative awareness component. Mindfulness skills through meditative breath work and body scans are two components that support the realignment of negative self-talk (Hughes et al., 2017; Park et al., 2015). Mindfulness helps participants connect to their present emotion and thinking while supporting their movement toward an outcome that is grounded in positivity vs. holding on to the traumatic foundation that contributed to the negative self-talk Hughes, Clark, Colclough, Dale, & McMillan, 2017; Park et al., 2015)

Mindfulness-Based Cognitive Therapy

Mindfulness-Based Cognitive Therapy (MBCT) is a modified form of MBSR that primarily focuses on participants diagnosed with Depression (Park et al., 2015). MBCT therapists teach clients how to break away from negative thinking so that they are able to fight off depression before the manifestation of a more profound depression (Baer, 2003;

Segal et al., 2012). MBCT aims to treat individuals with recurring episodes of depression or unhappiness, to prevent relapse (Segal et al. 2012). MBCT has shown a positive outcome for patients with major depressive disorder who have experienced at least three episodes of depression (Park et al., 2015; Segal et al., 2012). MBCT model is an 8-week program that uses group therapy once a week for two-hour sessions. At the weekly sessions, participants learned meditation techniques and basic principles of cognition regarding the way a person thinks and how a person feels (Baer, 2003; Park et al., 2015). Participants engage in self-regulatory practices outside weekly sessions, including breathing exercises and mindful meditation (Baer, 2003; Langer & Moldoveanu, 2000). MBCT believes that participants build a habit of practice through routine meditation practices that can support them whenever they feel overwhelmed by negative emotions or thoughts (Segal et al., 2012).

Summary of Outcomes and Assumptions

MBSR’s initial approach to incorporate mindfulness in psychotherapy treatment supported the adaptions of mindfulness in other evidence-based psychotherapy treatments, including Mindfulness-Based Stress Reduction (Gouda et al., 2016), Dialectical Behavior Therapy (Jennings & Apsche, 2014), Acceptance and Commitment Therapy and Mindfulness-Based Cognitive Therapy (Park et al., 2015). Nonetheless, mindfulness interventions share common aspirations, intentions, and diligence in reducing suffering for individuals (Baer, 2003; Monteiro et al., 2014). While each approach offers different methods to obtaining the shared goal, the overall foundation of each intervention utilized the primary philosophy of MBSR established by Jon Kabat-

Zinn during the westernizing of the original foundation derived from Buddhist meditative traditions (Gouda et al., 2016; Kabat Zinn, 2003; Park et al., 2015;Chi et al.,2018). The utilization of self-awareness, meditative awareness, and body movement supports each intervention to tackle the symptoms and behaviors individuals with depression, anxiety, stress, and chronic pain manage daily (Coyne et al., 2011; De Vibe et al., 2012; Hughes et al., 2017; Kabat Zinn, 2003; Park et al., 2015; Ruiz, 2010).

Research has associated mindfulness interventions with lower levels of emotional disturbance (depression, anxiety, and stress) and higher levels of subjective well-being (satisfaction with life) (Brown & Ryan, 2003) Gouda et al., 2016; Chi et al., 2018). Mindfulness interventions have also been associated with promoting greater interest and concern for life, shown by higher levels of self-compassion (Brown & Ryan, 2003), empathy for others (Gouda et al., 2016.), and environmental concerns (Park et al., 2015). Therefore, participation in mindfulness interventions shows various individual benefits; however, to reap maximum benefits of mindfulness, research suggests individual self-regulation by practicing mindfulness skills regularly (Brown & Ryan, 2003; Kabat Zinn, 2003; Watier & Dubois, 2016). Mindfulness intervention typically begins with programs lasting roughly five to eight weeks (Watier & Dubois, 2016). An assumption associated with these timelines is that a participant only needs five to eight weeks to develop all the skills necessary to eliminate symptoms and behaviors related to their struggle (Gouda et al., 2016; Kabat Zinn, 1994, 2003 Chi et al., 2018). However, Mindfulness interventions aim to provide a foundational blueprint associated with mindfulness skills to support individuals in utilizing skills outside of direct support (Gouda et al., 2016; Kabat Zinn,

1994, 2003; Chi et al., 2018). Furthermore, similar to adults, adolescents show promising findings when engaging in mindfulness as interventions are typically well-liked, enjoyable, and appreciative amongst participants (Burke, 2009; Hughes et al., 2017; Kabat -Zinn, 1994, 2003; Thomson et al., 2017).

A Brief History of Depression

In the Beginning

Depression is one of the most common manifestations of psychological distress in the United States (National Institute of Mental Health [NIMH], 2019). Major Depression, which is the chronic and reoccurring form of depression, is identified as one of the leading causes of disability in the United States for ages 15 to 45, with significant contributions to the overall global burden of disease (National Institute of Mental Health [NIMH], 2019). National surveys estimate that more than 16.1 million Americans and approximately 11–12% of adolescents have experienced a major depressive episode at least once in their life (Kessler et al., 2003; Merkangas et al.,2010). According to Twenge et al. (2019) and their collection of data for eight years from more than 600,000 adolescents and adults across the US for mood disorders and suicide-related outcomes, they discovered that more young people were showing increasing signs of depression through decreasing interest in life, and leisure activities, at rates much higher than that same age group a decade ago (Twenge et al., 2019).

Dating back to 400 B.C., depression has been a topic of interest in the health field, with historical documents written by healers, philosophers, and writers pointing to the long-standing existence of depression as a health problem (Hidaka, 2012; Kessler et al.,

2003; McLaughlin, 2011). Historically, finding ways to treat depression has come with challenges in demonstrating success in treatment outcomes (DeRubeis et al., 2008; Merikangas et al., 2010; Mojtabaii, Olfson, Han, 2016). Depression was initially called "melancholia," appearing in ancient Mesopotamian texts in the second millennium B.C. During this period, mental illnesses were thought to be the onset of someone being possessed by demons, which a priest then treated. These priests used exorcism techniques such as beatings, restraint, and starvation to fight depressive symptoms in individuals (Mojtabaii et al., 2016; Tasca et al., 2012). In contrast, early Roman and Greek doctors thought that depression was a biological and psychological disease and offered cognitive adjustments using gymnastics, massages, special diets, music, and baths, as well as a mixture of poppy extract and donkey's milk to treat depressive symptoms (Hidaka, 2012; Kessler et al., 2003; Tasca et al., 2012).

Enlighten Years (the 1700s–1900s)

During the late 1700s and early 1800s, some doctors and authors suggested that aggression was the real cause of depression (Clark & Beck, 2010; Cuijpers et al., 2014a; Schmertz et al., 2009). and treated individuals by offering exercise, music, drugs, and diet, as well as stressing the importance of discussing problems with a close friend or a therapist (Cuijpers et al., 2014a; Cuijpers et al., 2014a; McLaughlin K. A, 2011; Mojtabaii et al., 2016). However, other doctors thought that depression was caused by an internal conflict between unacceptable impulses and a person's conscience (DeRubeis et al., 2008; Khalsa et al., 2011; Richards, 2011). By the early 1900s, new therapies for depression were developed to include water immersion, which involved keeping people

underwater for as long as possible without drowning; the use of a unique spinning Stoll to cause dizziness, which was said to rearrange the contents of the brain into the correct positions; and electroshock therapy, involving electrical stimulation of the brain (Clark & Beck, 2010; DeRubeis et al., 2008; Mojtabaii et al., 2016; Richards, 2011; Tasca et al., 2012). During the mid-1900s, many individuals were engaging in surgical procedures such as having a lobotomy, surgical destruction of the frontal portion of a person's brain to trigger a sense of calmness. However, many patients noticed personality changes, the inability to make decisions, poor judgment, and some cases of coma or death following the procedure. By the late 1900s, fewer surgical procedures took place, and the onset of medication use began to become a standard treatment for depression. Psychiatry, which had previously looked to psychotherapy as their therapy of choice, started to emphasize the use of medications as primary treatments for mental illnesses (Cuijpers et al., 2014; Cuijpers et al., 2009; Hidaka, 2012; Kessler et al., 2003; Richards, 2011).

Millennium Treatment for Depression

Researching depression has taught us one thing; depression can be caused by both mental and physical causes (National Institute of Mental Health [NIMH], 2019; Pantic, 2014). With the increased usage of electronics, researchers see behaviors associated with social isolation, poor school performance, and impaired sleep as factors that contribute to depression (Pantic , 2014). According to the Health Insurance Coverage report (2016), people who suffer from depression often have other health problems, which come at a cost. On Average, a person with significant depression spends twice as much on healthcare annually as someone without depression (10, 673 vs. 4,283 in 2016) (Health

Insurance Coverage Report, 2016). Therefore, no single reason explains fully and account for all types of depression (DeRubeis et al., 2008; Egede et al., 2016; Khalsa et al., 2011). Mental health professionals believe that depression has multiple causes, including biological, psychological, and social factors (Edge et al., 2016; Kessler et al., 2003; NIMH, 2019; Pantic, 2014). Therefore, depression treatment has become a priority focus in mental health, health care, and education, lending its lens to new and innovative approaches to therapy in helping people overcome depression (Egede et al., 2016; Fournier et al., 2010; McLaughlin K. A, 2011). In 2019, depression medication was marketed as a priority treatment for depression (Egede et al., 2016; McCord, 2017). Medication may help relieve some of the symptoms of moderate and severe depression but does not cure the underlying problem and usually does not act as a long-term solution (DeRubeis et al., 2008; Fournier et al., 2010; Richards, 2011). Antidepressant medications also come with side effects and safety concerns, and withdrawal can be very difficult (Egede et al., 2016; McCord, 2017).

Additionally, newer therapies offer various treatment options for depression that require patients to engage, evaluate, and choose what best fits their needs (Egede et al., 2016; Fournier et al., 2010; Iselin & Addis, 2003; Khalsa et al., 2011;). With the incorporation of mindfulness, traditional evident-based psychotherapy treatments offer a lens and skills set in tackling depression (Gouda et al., 2016; Jennings & Apsche, 2014; Park et al., 2015). Mindfulness-Based Stress Reduction (Gouda et al., 2016), Dialectical Behavior Therapy (Jennings & Apsche, 2014), Acceptance and Commitment Therapy, and Mindfulness-Based Cognitive Therapy (Park et al., 2015) are forms of treatment that

are geared to treating depression both short and long term. Furthermore, the infusion of alternative supports such as vitamin and herbal regiments, acupuncture, and relaxation techniques like yoga which are grounded in mindfulness, have supported individuals who were no responding successfully to traditional cognitive therapy and antidepressant medications (Edge et al., 2016; Fournier et al., 2010; Iselin & Addis, 2003; McLaughlin, 2011). Besides medication, medical practitioners have outlined a healthier diet contributing to a better physical foundation, supporting increased energy throughout the day (Edge et al., 2016; McLaughlin, 2011; Wissow, 2016). Also, acupuncture and yoga offer an intentional approach to slow rhythmic breathing to induce a sense of calm, well-being, stress tolerance, and mental focus (Kabat-Zinn J, 1990; Van der Gucht et al., 2019; Wissow et al., 2016). Research suggests that a healthy body and intentional focus on breathing support minimizing depression symptoms (Huq et al., 2016; Kabat-Zinn J, 1990; Van der Gucht et al., 2019).

Adolescent Depression

Depression Among Adolescents in the United States

During the transition from childhood to adolescents, adolescents are at exceptionally high risk for depression (Mayo Clinic, 2019). Factors that are associated with an increased risk of developing adolescents depression include negative self-esteem, obesity, peer conflict, bullying, physical or sexual abuse, and academic performance (Mayo Clinic, 2019), contributing to nearly 14% of American youth being predicted to be diagnosed with depression before the age of 18 (Huq et al., 2016; McCord, 2017; Mojtabaii et al., 2016; Mullen S, 2018; Mundy et al., 2013). . In 2004, The World Health

Organization predicted depression as a burdensome psychiatric disorder in the 21st century (Vaugh-Coaxum et al., 2016). In 2019, Depression was one of the commonly diagnosed mental illnesses among adolescents in the US (McCord, 2017; Mojtabaii et al., 2016; National Institute of Mental Health [NIMH], 2019). According to the American Psychiatric Association (2019), 50% of cases of mental illness begin by age 14, with the tendency to develop depression nearly doubling from age 13 to 18 (Mullen, 2018; Munday et al., 2013; Vaugh-Coaxum et al., 2016;). Furthermore, Hispanic adolescents between the ages of 12-18 (Huq et al., 2016; Mojtabaii et al., 2016) initial reports to determine depression criteria show symptoms relating to 46.7% feeling sadness or hopelessness compared to 37.9% of Whites and 33.9% of African Americans (McCord, 2017; Vanghn-Coaxum et al., 2016).

Depression Among Hispanic Adolescents in the United States

The Hispanic population is a vulnerable, underserved, and high need for mental health care (Mojtabaii et al., 2016; Potochnick & Perreira, 2010; Velasco-Mondragon et al., 2016). Characteristics such as lower socioeconomic status, lower education level, and occupation have increased mental illnesses among Hispanics (O'Connor et al., 2008; Velasco- Mondragon et al., 2016). Hispanics living below the federal poverty level (20.7%) is doubled that of non-Hispanic whites (9.0%) (U.S. U.S. Census Bureau, 2002; Zambrana & Carter-Pokras, 2010). Moreover, 32.1% of Hispanics lack health insurance, compared to 10.4% of non-Hispanics (U.S. U.S. Census Bureau, 2002; Zambrana & Carter-Pokras, 2010), impacting their ability to access health care. Furthermore, 36% of first-generation immigrant Hispanic youth report experiencing sadness and hopelessness,

15.9% have considered suicide and 10.2% have attempted suicide (Huq et al., 2016; Potochnick, & Perreira, 2010). Hispanic adolescents are less likely to be aware of mental health symptoms and less likely to seek mental health care (O'Conner et al., 2008; Vanghn-Coaxum et al., 2016; Velasco-Mondragon et al., 2016). Many times, rather than seek help from school professionals or parents, Hispanic adolescents may begin to self-medicate with drugs and alcohol (Mullen S, 2018; Rubens et al., 2018; Velasco-Mondragon et al., 2016). Even with proper diagnosis, only 40% of Hispanic adolescents diagnosed with depression receive treatment due to barriers such as cost, concerns about mental health stigma, and lack of access to resources (DeRubeis et al., 2008; Mojtabaii et al., 2016; Mullen S, 2018).

Treatment Barriers for Hispanic Adolescents with Depression

For many Hispanics, life in the U.S is coupled with multiple socioeconomic stressors, which places them at a higher risk for depression and other poor health-related quality of life outcomes (Fergusson & Woodward, 2002; McHugh et al., 2013; Rubens et al., 2018). With limited access to mental health professionals, family physicians and pediatrics are often responsible for detecting and treating adolescent depression (DeRubeis et al., 2008; Vanghn-Coaxum et al., 2016; Wissow et al., 2016). Physicians detecting depression symptoms may be a barrier for Hispanic adolescents due to reports showing that Hispanic adolescents who report symptoms to physicians are dismissed or missed diagnosis about 62%-84% of the time as physicians refer to their signs as just a "phase" that will pass (Fernandez et al., 2011; NIMH, 2018; Velasco-Mondragon et al., 2016; Wissow, 2016). Also, when treatment options are given, Hispanics often prefer

counseling services rather than pharmacologic treatment, which is a primary treatment option when experiencing depressive symptoms (Fernandez Y Garcia et al., 2011; McHugh et al., 2013). However, Hispanics show a higher acceptance of psychotherapy over pharmacotherapy (DeRubeis et al., 2008; McHugh et al., 2013). Moreover, Hispanics prefer to use more alternative care instead of conventional care such as (clergy, pastoral, and family counseling) due to generalized mistrust among Hispanics regarding traditional care systems (Fernandez Y Garcia et al., 2011; Potochnick & Perreira, 2010) and perceived discrimination (McHugh et al., 2013). With the integration and practice of mindfulness intervention, Hispanic adolescents may connect more authentically with the support mindfulness offers. Therefore, Hispanics access to an approach that a physician does not drive, instead explored by their current state of being (Rubens et al., 2018; Velasco-Mondragon et al., 2016; Wissow, 2016), supports Hispanics having knowledge and the option of mindfulness engagement of depression earlier along the depression spectrum. Furthermore, seeking help for emotional problems is highly stigmatized among minorities than among whites, deeming seeking treatment culturally unacceptable (Fernandez Y Garcia et al., 2011; Ford-Paz et al., 2015; Rubens et al., 2018). Therefore, untreated mental health conditions in the Hispanic community may lead to debilitating and potentially life-long consequences (Fergusson & Woodward, 2002; McHugh et al., 2013). If chronic or severe depression occurrent during early adolescence, substance use is significantly higher once they reach 18 years of age (Mojtabaii et al., 2016; National Institute of Mental Health [NIMH], 2018; Rubens et al., 2018). Adolescent depression also correlates with multiple psychiatric disorders later in life, educational impairments,

increased risk of unplanned pregnancy, increased self-injuring behaviors, and increased risk of suicide (Fernandez Y Garcia et al., 2011; Ford-Paz et al., 2015; Mullen S, 2018).

Mindfulness for Adolescents With Depression

Mindfulness as an Intervention for Adolescents

Many intervention methods have been implemented to prevent and reduce depression in adolescents, including Traditional treatments such as prescribed antidepressants, cognitive-behavioral therapy (CBT), and psychological counseling (DeRubeis, Siegle, Hollon, 2008; Ford – Paz et al., 2015; Huq, 2016). CBT serves as the most popular form of therapy with adolescents as it incorporates working directly with a practitioner to change a behavior or thinking patterns (DeRubeis, Siegle, Hollon, 2008; Ford – Paz et al., 2015; Huq, 2016). CBT is often the form of therapy utilized by school counselors and outpatient services, typically accessible to adolescents (DeRubeis, Siegle, Hollon, 2008; Ford – Paz et al., 2015; Huq, 2016). However, emerging treatments such as mindfulness interventions have also gained popularity as a supportive or alternative evidence-based practice in treating adolescent depression in the last decade (Felver et al., 2016; Kallapiran et al., 2015; Zoogman et al., 2015). Mindfulness practices increased in the United States between 1970-2000 (Brown & Ryan, 2003; Burke, 2009; De Vibe et al., 2012; Vaugh-Coaxum et al., 2016). Although mindfulness practices have been widely disseminated and accepted in the adult population in clinical and non-clinical settings, Mindfulness Interventions for adolescents is a new approach with limited empirical data to support adolescent's connection to mindfulness as a treatment approach (Van der Guht et al., 2019; Vaugh-Coaxum et al., 2016; Young et al., 2018; Zoogman et al., 2015).

Participants in mindfulness interventions are taught to bring their attention or awareness to the present moment while noticing thoughts and emotions as a passing state, which allows them to return their attention to the mindfulness exercise vs. the adverse state (Bishop et al., 2004; Brown & Ryan, 2003; Burke, 2010; Van der Gucht et al., 2019). The frequent use of the definition illustrates the intent MBSR, founded by Jon Kabat-Zinn, conceptualizes mindfulness for individuals with depression (Gouda et al., 2016; Kabat-Zinn J, 1990; Kabat-Zinn, 2003; Van der Gucht et al., 2019). Kabat -Zinn's (1990) original purpose for MBSR was to help patients with physical illness deal with pain, stress, and negative emotions in behavioral medicine settings. However, since the 1970s, mindfulness practices have been used in the general population for stress, anxiety, and depression (Ford – Paz et al., 2013; Rubens et al., 2018; Van der Guht et al., 2019; Virgili, 2015). Mindfulness has been utilized with adolescents to provide a self-regulated coping strategy (DeRubeis, Siegle, Hollon, 2008; Ford – Paz et al., 2013; Huq, 2016). Rubens et al. (2018) express that children are experiencing challenges with coping in the 21st century due to extreme peer pressure and academic performance demands. Schools are beginning to offer mindfulness activities during the school day to combat issues. Some activities include; a moment of silence in the morning, mindfulness breaks during academic instruction, peace rooms in school (where students can go to get a minute throughout the day), as well as explicitly targeting high-risk groups to conduct weekly sessions (Fung et al., 2016; Gouda et al., 2016; Werner-Seidler et al., 2017).

Adolescents being exposed to this intervention may stimulate a change in re-experiencing a situation (Fung et al., 2016; Gouda et al., 2016). This process of dis-

identifying from the conscious content enables the cognitive change that may influence the way adolescents perceive a negative experience by helping to shift their perception and overall stimulate a positive state of being (Monshat et al., 2013; Van der Gucht et al., 2019; Young et al., 2018). The practice of mindfulness skills may also improve adjustment among adolescents enhancing self-regulatory capacities (Gouda et al., 2016; Kabat-Zinn, 1990; Vaugh-Coaxum et al., 2016; Van der Guht et al., 2019).

Mindfulness as an Intervention for Hispanic Adolescents

Hispanics represent over 17% of the U.S. population and are the largest ethnic group in the United States and the fastest-growing (Ford- Paz et al., 2015; Francisco et al., 2018; Huq, Stein, and Gonzalez, 2016; Rubens et al., 2018). Yet, despite being such a large population group, Hispanics are under-studied and under-represented in studies of health, psychological well-being, and mind-body interventions (Francisco et al., 2018, Francisco et al., 2018; McHugh et al., 2013; U.S. U.S. Census Bureau, 2002). Although mental health challenges are present, Hispanics are seldom represented in research studies and health-promoting programs, in part due to a lack of cultural appropriateness by researchers and low levels of trust of the research community (Rubens et al., 2018; Vanghn-Coaxum et al., 2016; Velasco-Mondragon et al., 2016). One aspect to consider that could be appealing to Hispanic adolescents is how mindfulness sessions are conducted, often in a group setting. Groups may offer Hispanic adolescents a similar format that does feel like an unknown environment due to the similarity to class environments or team sports (Egede et al., 2016; Fournier et al., 2010; Rubens et al., 2018; Khalsa et al., 2011; Vanghn-Coaxum et al., 2016). Mindfulness interventions may

also offer a unique involvement with peers, which can be intriguing for adolescents as a group may help promote motivation and positive peer relationships (Kabat Zinn, 1990; Vaugh-Coaxum et al., 2016; Van der Guht et al., 2019). Furthermore, the group setting in mindfulness engagement may be appealing due to the associated cultural norm of having a collectivistic worldview in Hispanic communities (Mullen S, 2018; Rubens et al., 2018; Velasco-Mondragon et al., 2016).

Mindfulness is a practice one engages informally and informally (Gouda et al., 2016; Fung et al., 2016; Kabat Zinn , 1990, 2003; Chi et al., 2018). Formal practice is rooted in the MBSR structure consisting of daily sitting meditations, lasting typically 45 minutes, which the practitioner observes thoughts, feelings, and bodily sensations, supporting the use of breath as a foundational measure to focus and re-direct attention on the present moment (Kabat Zinn , 1990, 2003; Chi et al., 2018). Informal practice takes a leisure route to mindfulness while keeping the foundational qualities of MBSR by utilizing yoga, walking meditation, body scans, mindful eating based on individual preference (Kabat Zinn , 1990, 2003; Chi et al., 2018). Nonetheless, whether formally or informally, mindfulness core characteristic is rooted in attentional training while developing emotionally positive attributes including kindness, compassion, and gratitude to support in evoking and amplifying emotions (Fung et al., 2016; Chi et al., 2018; Hölzel et al., 2011) suggesting that mindfulness confers its benefits through three core skill sets: Emotion Regulation, Attentional Control, and Self-Awareness.

Adolescent depression symptoms such as feelings of sadness and hopelessness, lack of focus, fixation on past or future failures, and self-blame are aligned to direct

changes in which mindfulness implementation looks to restructure (Hidaka, 2012; Kessler et al., 2003; McLaughlin, 2011). There have been limited findings associated with the overall experience of Hispanic adolescents with depression engaging in mindfulness interventions to decrease depressive symptoms (Bluth et al., 2016; Fung et al., 2016.; Schonert-Reichl & Lawlor, 2010; Segal, 2012; Khoury et al., 2013). Therefore, Research that works directly with Hispanic adolescents engaging in mindfulness Interventions may be one way to help address the unmet health needs of Hispanics in the U.S (Thomson et al., 2017; Chi et al., 2018; Young et al., 2018).

Summary and Conclusions

This explanatory case study seeks to corroborate, extend, and or dispute aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms (De Vibe et al., 2012; Gouda et al., 2016; Khoury et al., 2013). Lower socioeconomic status, lower education level, and limited access to healthcare are vital characteristics of mental illnesses among the Hispanic population (O'Connor, Anders, Balcazar, Ibarra, Perez, Flore, Ortiz, & Bean., 2008; Velasco-Mondragon et al., 2016). However, due to cost concerns, mental health stigmas, and lack of access to resources (DeRubeis et al., 2008; Mojtabaii et al., 2016; Mullen S, 2018). Hispanic adolescents appear to be vulnerable and underserved regarding mental health treatment options for depressions or depressive symptoms (Mojtabaii et al., 2016; Potochnick & Perreira, 2010; Velasco-Mondragon et al., 2016). Considering mental health treatment options for depression aligned with the cultural appropriateness of the Hispanic community is a relative theme throughout this literature (O'Conner et al., 2008; Vanghn-

Coaxum et al., 2016; Velasco-Mondragon et al., 2016). A foundational concept outlined in this study relates to the Hispanic culture's comfortability and preference for traditional therapeutic services rather than pharmacologic treatment (Fernandez Y Garcia et al., 2011; McHugh et al., 2013), as well as mindfulness ability to combat critical limitations associated with Hispanic adolescent's ability to seek mental health treatment (Mojtabai, Olfson, Han, 2016, Vanghn-Coaxum et al., 2016, Velasco-Mondragon et al., 2016; Chi et al., 2018). Including mindfulness as a treatment option being self-monitored, self-guided, and limited to no risk associated with treatment (Gouda et al., 2016, Mojtabaii, Olfson, & Han, 2016, Vaughn-Coaxum et al., 2016; Chi et al., 2018).

Mindfulness interventions have been utilized with adolescents to provide a self-regulated coping strategy for mental illnesses, including depression, anxiety, stress, and chronic pain (DeRubeis, Siegle, Hollon, 2008; Ford – Paz et al., 2013; Huq, 2016). A theme associated with mindfulness implementation with adolescents is positive outcomes (Chi et al., 2018; Huq, 2016). Mindfulness has been identified as helpful by participants, and quantitative findings show a positive impact on self-esteem, perceived stress, and depressive symptoms (Bluth et al., 2016, Chi et al., 2018; Fung et al., 2016, Young et al., 2018, Chi et al., 2018). However, little is known about the effectiveness of interventions for treating adolescent conditions (Burke, 2009; DeRubeis, Siegle, Hollon, 2008; Ford – Paz et al., 2013; Huq, 2016; Segal, 2012). Research is expanding, giving the gained popularity of mindfulness-based interventions as a supportive evidence-based practice in treating adolescent depression in the last decade (Felver et al., 2016; Kallapiran et al., 2015; Zoogman et al., 2015).

Understanding the experiences of Hispanic adolescents using mindfulness interventions may help mental health practitioners, school counselors, and behavioral interventionists. This study includes information that readers may use to promote social change and fill a gap in the literature by providing relevant information that would be helpful when considering the implementation of mindfulness interventions as a tool for coping with depressive symptoms with Hispanic adolescents (Edwards et al., 2014, Chi et al., 2018). Chapter 3 contains the methodology for this explanatory case study, including essential sections such as research design and rationale, the role of the researchers, methods, instrumentation, data collections, and data analysis plan.

Chapter 3: Research Method

A case study was utilized to understand the experiences of Hispanic adolescents using mindfulness as an intervention tool. When selecting this research method, three conditions were considered: (1) the research questions, (2) the amount of control over events, and (3) the degree of focus on contemporary events, as opposed to historical events (Yin, 1989). Yin (1989) expresses that research seeking "how" and "why" questions fall into the category of explanatory and that case studies, as opposed to quantitative methods, are the preferred strategy when such questions are being posed. Merriam (2009) confirms, "the decision to focus on qualitative case studies stems from the fact that this design supports researchers when they are interested in insight, discovery, and interpretations rather than hypothesis testing" (p.42). Furthermore, case studies are proper when the research has little control over events and when the research focuses on a contemporary phenomenon within some real-life context (Yin, 1989).

For this explanatory case study, I corroborated aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms. Understanding the experiences of Hispanic adolescents using MIs may be helpful for mental health practitioners, school counselors, and behavioral interventionists who work with Hispanic adolescents with depressive symptoms to develop self-guided interventions for this population. This study includes information that readers may use to promote social change and fill a gap in the literature by providing relevant information that would be helpful when considering the implementation of MIs as a tool for coping with depressive symptoms with Hispanic adolescents (Edwards et al., 2014, Chi et al.,

2018). This chapter includes the following sections: (a) research design and rationale, (b) role of the researcher, (c) methodology, (d) data collections, (e) data analysis, (f) issues of trustworthiness, (g) potential research bias, and (h) summary.

Research Design and Rationale

The following phenomenon was investigated: How do stakeholders characterize MIs for Hispanic adolescents with depression or depressive symptoms in an urban setting. The explanatory case study methodology provides a framework to explore the real-life experiences of those adolescents with depression or depressive symptoms engaging in mindfulness as an alternative intervention tool to answer "how" and "why" mindfulness may benefit Hispanic adolescents with depression or depressive symptoms (Yin, 2013).

Research Question

The following interrogatives are guides to this study:

1. How do stakeholders characterize MIs for Hispanic adolescents with depression or depressive symptoms in urban settings?
2. Do participatory characterizations corroborate, extend, and or dispute mindfulness as an alternative psychotherapy treatment tool for Hispanic adolescents with depression or depressive symptoms in urban settings?

Research Design

The research design for this study was a single explanatory case study. The explanatory case study design method was appropriate for this study, which was designed to explore and corroborate the real-life experiences of Hispanic adolescents with

depression or depressive symptoms engaging in MIs to dispute or extend aspects of the model (Khoury et al., 2013; Schonert-Reichl & Lawlor, 2010; Yin, 2013).

The study design created a holistic view of Hispanic adolescents with depression or depressive symptoms and their real-life experiences when engaging in MIs (Yin, 2013). A case study design was appropriate for this study to organize the data to enhance an understanding of the MI for Hispanic adolescents in an urban setting in the Southern United States with depression or depressive symptoms (Yin, 2013). The case study design provides relevant information to implementing MIs in an urban setting for an alternative psychotherapy treatment tool for Hispanic adolescents with depression or depressive symptoms (Yin, 2013). The study results provide other mental health practitioners, school counselors, and behavioral interventionists who work with Hispanic adolescents with depressive symptoms a supportive structure for developing self-guided interventions for this population (Khoury et al., 2013; Yin, 2013).

A qualitative method for this study was used to understand the collective experiences of the unit of analysis comprised of Hispanic adolescents with depression and other stakeholders (Yin, 2013). The data collection narrative format helps conduct a qualitative research study (Yin, 2013). This study focused on the phenomenon's relevance and does not provide a conclusion but rather understanding of the population's experience (Woolcock, 2013; Yin, 2013). The following section addresses the role of the researcher and specify the methodology for potential replication of future studies.

Role of the Researcher

I have been working in education for over 12 years and hold a Master of Arts in Counseling. Engaging in alternative therapeutic practices, such as mindfulness, was introduced to me in 2014 to help with discipline at the campus level. Since 2014, I have continued engaging in local and national professional training and conducting mindfulness sessions for adolescents and adults. I have facilitated over 100 group sessions that utilized mindfulness as a foundational practice. My work with adolescents in mindfulness has sparked the interest of other educational professionals, and I have facilitated training for over five other collaborated educational institutions. One way that I engage students in mindfulness is through group facilitation. Throughout this research, the term group sessions were used. The term refers to adolescents engaging in mindfulness with a facilitator and peers present.

Connection to Environment

I was employed and served as an administrator for 3 years at the high school where the participants were selected. I do not serve as a current administrator at the high school due to reassignment to another campus in the district three years ago. I do not have regular contact with any students at the campus level, and my collaboration with the high school is strictly from a leadership lens as I do have regular contact with the leadership team at the campus level. The power differentials between participants in the study, and myself as a researcher were limited due to this relationship dynamic.

The high school is unique, as it is considered a restorative justice campus in the school district. The campus mission is based on the implementation of mindfulness

practices within the behavioral and intervention structure. Therefore, all students have a baseline knowledge of mindfulness and practices associated with mindfulness. Students and staff practice mindfulness and discuss social justice issues on a weekly bias. Therefore, meeting in this format may not evoke power over participants due to the historical tradition of meeting in a group setting at the campus level.

Connection to the Study

For this explanatory single-case study, I was the sole researcher-as-analyst responsible for collecting, analyzing, and interpreting data. The participants of the study may have remembered me as a former high school administrator. Therefore, the relationship threshold for each participant varied, as I have met and supported many students in their community with behavioral, academic, and socio-emotional concerns. My role shifted 3 years ago when I was reassigned to another campus in the district. However, my knowledge of the campus culture and direct role as the researcher supported my attempt to understand how students naturally interact with mindfulness practices (Chi et al., 2018).

My role as the researcher was to collect data using semi-structured interviews from teachers and parent/guardians and reflective notes from the group facilitator and youth during mindfulness group weekly sessions. Facilitator reflection from the group sessions supported in gathering information regarding nonverbal expressions, communication between participants, and documentation of any additional context that is needed to fully understand the experiences of those participating (Yin, 2013). A researcher bias that is most pervasive is confirmation bias, which occurs when a

researcher forms a hypothesis or belief and uses respondents' information to confirm that belief (Yin, 2013). As a researcher with experience in the community and mindfulness, it was essential to minimize confirmation bias. Therefore, constant reevaluating through participants written responses and participants review of facilitators observational notes supported in minimizing confirmation bias (Yin, 2013)

Participants of the group sessions received materials related to mindfulness tools, including a talking piece, notebook/journal, t-shirt, and small snacks during sessions. These materials are aligned with the school's affinity group resources for students who participate. The mindfulness group is a regular school program that support students each year. Therefore, I did not be using personal funds to provide participants with school purchased materials.

Methodology

Unit of Analysis

The unit of analysis was from a single urban high school located in the Southern U.S. community. The high school was a public school, comprised of 98% Hispanic youth. I used Hispanic youth with depression or depressive symptoms for the MI group in the spring of 2022. For this study, I gathered data for Hispanic adolescents identified as depressed or having depressive symptoms between the ages of 14 and 18 using a convenience sample. The unit of analysis included (a) mindfulness group facilitator, (b) parents, (c) teachers, who have students engaging in the mindfulness group, and (d) Hispanic youth with depressive symptoms, who engaged in the mindfulness group for the length of program intervention (Monshat et al., 2013; Thomson et al., 2017).

Understanding the experiences of Hispanic adolescents on the spectrum for depression engaging in MIs provides helpful information for mental health practitioners, school counselors, and behavioral interventions when developing prevention treatment and rehabilitation for adolescents with depression or depressive symptoms.

Kabat-Zinn’s (1990) MBSR model was utilized to corroborate, extend, or dispute aspects of the mindfulness model for adolescents with depression or depressive symptoms. Kabat-Zinn’s original focus for MBSR was based on integrating mindfulness practices in the clinical setting for patients with chronic pain (Virgili, 2015). In alignment with Kabat-Zinn’s original framework, the timeframe of 8-weeks with 1-hour direct instruction weekly sessions corroborated the value of creating a structured foundation at the initial starting point of mindfulness integration (Brown & Ryan, 2003; De Vibe et al., 2012; Ramel et al., 2004). Furthermore, identifying stakeholders and participatory characterizations associated with “how” Hispanic adolescents with depressive symptoms engage in the mindfulness model supported extending or disputing mindfulness practices utilized in the case study.

Inclusion Criteria

I employed a convenience unit of analysis and utilized a participant criterion to determine eligibility for a unit of analysis. A convenience unit of analysis and a clear criterion aided in deciding specific participant attributes related to Hispanic youth, teachers of hispanic youth, and parent/guardian of Hispanic youth who are involved in mindfulness (Farrokhi & Mahmoudi-Hamidabad, 2012; Van Iddekinge et al., 2012). The convenience unit of analysis relies on data collection from a conveniently available

population (Farrokhi & Mahmoudi-Hamidabad, 2012), in this case, Hispanic youth adolescents who attended the school with a 98% Hispanic youth population. The criterion identified characteristics that the unit of analysis needed to meet to be appropriate for the study (Van Iddekinge et al., 2012; see Appendix A). The supported unit of analysis for parent/guardians, teachers, and facilitator also contributed to the depth of understanding the experiences of Hispanic youth with depression or depressive symptoms engaging in MIs (Yin, 2013).

Four Hispanic adolescents with depression and depressive symptoms were identified for this case study (Yin, 2013). The number of Hispanic youth participants were decided based on the typical caseload of students with depressive symptoms who work with the counselors at this particular school during any given year, which typically ranges between 13 to 20 cases per year (Evans & Lewis, 2018; Farrokhi & Mahmoudi-Hamidabad, 2012). Based on the counselor's yearly estimation, this study strived for the unit of analysis for Hispanic youth to represent 40%-50% of the lower end of the typical caseload for counselors at the school of choice.

One teacher of Hispanic youth was identified for this case study. A teacher of record was required, which represented a consistent member of the students' daily engagements as a primary teacher in their daily schedule. The core teacher engaged in a semi-structured interview to gain a deeper understanding of the students' ability to display self-control and self-manage their emotions and behaviors when engaging in conflict or stressful experiences when in the classroom environment. Therefore, the core

teacher was appropriate, as they are the teacher of record and function as a consistent teacher throughout the school year.

One parent/guardian of the Hispanic youth was identified for this study. One parent/guardian was identified to engage in the study to gain a deeper understanding of the parents beliefs and opinions surrounding their youths engagement in the MI associated with the student's ability to display self-control and self-manage their emotions and behaviors when engaging in conflict or stressful experience (Evans & Lewis, 2018; Hyett et al., 2014).

This case study was large enough to allow for a new and richly textured understanding of the phenomenon but small enough to unfold the deep, case-oriented analysis, which supported reaching saturation with the units of analysis (Merriam, 2009; Sandelowski, 1995).

Table 2

Inclusion Criteria

Unit of analysis	Hispanic youth	Teacher of Hispanic youth	Parent/guardian of Hispanic youth
Number of participants	4	1	1
Criterion	have seen a high school counselor at least twice for depressive symptoms Enrolled in high school	teacher of record	Legal parent/guardian English speaking

Site Permission and Informed Consent

Site Permission was initially collected from the school of choice for this study prior to parent/guardian, and teacher informed consent (Appendix A). The researcher reviewed the letter of permission with the authorized school administrator and retained a signature to start conducting research. The signed letter served as approval to identify students, and gain informed consent from parent/guardians, and teachers.

Once the students were identified, the researcher gained informed consent from the parent/guardian and teacher of youth engaged in the case study (Appendix C). Although youth was informed of the study's criteria and general overview (Appendix C), no official informed consent was needed as I collected data from documentation provided by the group facilitator and campus administrator. When conducting this study, I did not have contact with youth involved in the study. (Yin, 2013). The group facilitator provided reflections during the weekly school activity for students, therefore the reflections of the youth engaged in mindfulness did not change the delivery of the educational service. The chart below identified "when" and "how" consent was gathered for each sample group. I reviewed the study and informed consent with participants by sharing information about their rights and the study guidelines. Informed consent included potential benefit, harm, and the participant's rights to opt-out of the study at any point without consequence.

Table 3

Informed Consent

Informed consent	Parent/guardian of hispanic youth	Teacher of hispanic youth	Group acilitator
When	After establishing participant criteria is met for youth	After parent/guardian has given consent for youth to engage in study, and before youth engages in 1st mindfulness group session	After parent/guardian and teacher have given consent for study and before youth engages in 1st mindfulness group session
How	**Phone**	**Virtual**	**Virtual**

Data Collection

The following section addresses the instrumentation used for data collection for the next sample groups: facilitator, youth, teachers, and guardian/parents.

Instrumentation

The instrumentations used for this study included Semi-Structured Interviews, Document Analysis, and Reflections. The table below outline the instruments used in the study, the purpose, and how the instruments were utilized in the study.

Table 4

Instrumentation

Stakeholder	Instrument	Purpose	How to Use
Parent/guardians & teachers	Semi-structured interviews	Understand the perspective of teachers and parents' beliefs and opinions surrounding participants engagement in the mindfulness interventions	• Phone/virtual • 30 minutes, private setting

Facilitator	Document analysis	Gain an understanding of the participant's receptiveness to Mindfulness as an Intervention	• Pre-determined reflection • written reflection captured at the end of weekly groups • reviewed and interpreted for trends/meanings, • signed by facilitator
Hispanic adolescents	Independent reflection	understand the real-life experiences of the adolescents when engaging in mindfulness interventions for depression or depressive symptoms	• pre-determined sessions topics • Structure: *meditation, mindfulness practice, independent reflection, whole group discussion*.

Sample Recruitment and Data Collection Process

Yin (2013) argues the characteristics of case study research are the delimitator of the case, viewing case studies as an integrated system. Thereby, the researchers may specify the phenomenon of interest and draw boundaries in what they inquire about making their case (Yin, 2013). For this explanatory case study, four sampling groups were identified (facilitator, youth, teachers, and parents) to create a holistic description and analysis of the bounded phenomenon in understanding the perspective of Hispanic youth with depression or depressive symptoms engaging in mindfulness interventions.

An explanatory case study was appropriate in gathering data to determine how and why implementing mindfulness practices are an essential alternative psychotherapy intervention for adolescents with depression or depressive symptoms. The data collected supports the research questions generated for this research study. The gathered data also

includes details to produce specific feedback on parental, teacher, and facilitators perspectives of the mindfulness interventions implementation with Hispanic adolescents in an urban setting with depression or depressive symptoms. Data was collected using multiple data collection forms, including semi-structured interviews through audio and transcripts, Document Analysis in the form of reflective notes (Yin, 2013)**.** The next section highlights the following: recruitment of sample, instrumentation rationale, and data collection for parents, teachers, facilitator, and youth.

Parent/Guardian

Consent. School counselor identified potential youth participants based on inclusion criteria. After identification, the student support administrative assistant sent parent/guardians of potential youth participants and email about research interest. A request for interested parent/guardian participants was to reply to the email within seven days to identify youth participants for the study. The researcher followed up by telephone to schedule a one-on-one phone appointment to discuss informed consent at length and ensure that youth participant parent/guardians have a general understanding of their rights. Once the parent/guardian completed the one on one phone call, informed consent was captured through a signed document using DocuSign.

Data Collection. Semi-Structured Interviews were employed to understand the perspective of parents beliefs and opinions surrounding participants engagement in the mindfulness interventions associated with the student's ability to display self-control and self-manage their emotions and behaviors when engaging in conflict or stressful experience (Evans & Lewis, 2018; Hyett et al., 2014). Semi-Structure Interviews were

essential in creating a fluid dialogue between parent and researcher (Evans & Lewis, 2018; Monshat et al., 2013). The semi-structured interviews were essential gaining a deeper understanding of parental beliefs associated with their student's engagement in the mindfulness intervention. Gaining parental perspective may support mental health practitioners, school counselors, and behavioral interventions when developing prevention treatment and rehabilitation services for adolescents with depression or depressive symptoms (Evans & Lewis, 2018; Monshat et al., 2013; Young et al., 2018). Furthermore, semi-structured interviews serve as an appropriate instrument when those being questioned have a low level of awareness of the subject or when there are issues that participants do not typically feel comfortable discussing, such as values, intentions, and ideals (Evans & Lewis, 2018; Hyett et al., 2014).

Before implementing the first semi-structured interview for parent/guardians, a demographic survey was administered during the one on one phone meeting after gaining informed consent. The demographic survey consisted of general questions that identified foundational characteristics to determine baseline engagement in mindfulness and commitment to the study. This information served as foundational insight when interpreting how youth characterized their current depressive and baseline practices to support depressive symptoms. The semi-structured interview for this study included guided questions *(*Appendix E*)* related to gaining a deeper understanding of the stakeholder's perception of Hispanic adolescents with depression or depressive symptoms engaging in mindfulness interventions. Interviews took place on the telephone using the "otter" audio recording tool.

Teacher

Consent. Before the first mindfulness group with youth participants, the student support administrative assistant sent youth participant teachers an email about research interest. A request for interested teacher participants was to reply to the email within seven days to identify teachers for the study. The researcher followed up by virtual meeting with teachers using the Microsoft "teams" platform to schedule a one-on-one phone appointment to discuss informed consent at length and ensure that teachers had a general understanding of their rights. Once the teacher completed the virtual meeting, informed consent was captured through a signed document using DocuSign.

The teacher engaged in semi-structured interviews to gain a deeper understanding of the student's ability to display self-control and self-manage their emotions and behaviors when engaging in conflict or stressful experiences when in the classroom environment (Appendix E).The teacher is appropriate for this study as they are the teacher of record and function as a consistent teacher throughout the school year. During the virtual meeting, the researcher presented available timeslots to conduct the first interview. The timeslot were 30 minutes in length and between 7:00am – 6:00pm, which aligns with school reporting hours. All interviews took place using the team's platform and "otter" recording device.

Data Collection: Semi-structured interviews were essential in capturing detailed teacher responses specific to each teacher's individual experience to mindfulness interventions (Evans & Lewis, 2018; Gill et al., 2008; Young et al., 2018). The specific experience of each teacher contributed to an increased level of understanding for mental

health practitioners, school counselor, and behavioral interventions when developing prevention treatment and rehabilitation serves for Hispanic adolescent youth with depression or depressive symptoms (Evans & Lewis, 2018; Monshat et al., 2013, Thomson et al., 2017; Young et al., 2018). Utilizing an explanatory qualitative case study supported understanding and enhancing knowledge regarding a topic that has not been thoroughly explored for the Hispanic adolescent's demographic (De Vibe et al., 2012; Khoury et al., 2013; Park et al., 2015; Segal et al., 2012). Data collection for this study aided in gaining an in-depth understanding and perception of Hispanic adolescent's perspective and responsiveness when engaging in mindfulness interventions for eight weeks.

Youth Recruitment

Student Assent. After obtaining IRB approval, an email was sent to the two school counselors in the single urban high school in a Southern U.S. community named for the study to determine possible youth participants based on inclusion criteria identified for the study. Possible youth required meeting with the counselors for at least two or more sessions regarding depressive symptoms to meet participant criteria. Additionally, counselors identified that parent/guardian for the youth identified has been informed about the counseling session related to depressive symptoms. An email was sent to the parent/guardians with a detailed description of the study to seek approval from the parent/guardian for participation (Appendix C).

Data Collection. Youth reflective notes were used to collect youth's data during the weekly one-hour mindfulness group. The goals of the reflective notes were to

understand the real-life experience of the adolescent when engaging in the weekly mindfulness interventions for depression or depressive symptoms. Participants engaged in the mindfulness interventions through an 8-week mindfulness group structure (Monshat et al., 2013). The eight weeks were determined based on the original length of KabatZinn J's (1990) stress reduction program known as Mindfulness-Based Stress Reduction. Using reflective notes s a primary instrumentation was essential in gaining a deeper understanding of the youth's experience, beliefs, and the meanings associated with their collective views about mindfulness (Creswell & Poth, 2018; Kabat Zinn , 1990; Young et al., 2018). The mindfulness group structure may support mental health practitioners, school counselors, and behavioral interventionists to understand the real-life experience of Hispanic adolescents with depression or depressive symptoms engaging in mindfulness intervention and their beliefs associated with their experiences (Creswell & Poth, 2018; Young et al., 2018). Reflective notes were pre-determined questions and prompts that guided a consistent structure in capturing the youth's responses. Additionally, the group session structure remained consistent throughout the 8-week process (Appendix F) Each mindfulness group session had the following components: meditation, mindfulness practice, independent reflection, whole group discussion.

Mindfulness Group Facilitator

Data Collection. The Mindfulness group facilitator utilized archival Analysis in the form of reflective notes to understand the participant's receptiveness to Mindfulness as an Intervention. Reflective notes were captured at the end of the weekly mindfulness

group sessions. The researcher reviewed the notes to elicit meaning, gain understanding, and develop empirical knowledge (Bowen, 2009; Creswell & Poth, 2018). This form of documented analysis supports mental health practitioners, school counselors, and behavioral interventionists to identify student receptiveness when engaging in mindfulness intervention, which may support efforts in developing prevention treatment and rehabilitation services for adolescents with depression or depressive symptoms (Bowen, 2009; Creswell & Poth, 2018; Young et al., 2018). The reflective notes for this study were pre-determined using a reflection document captured and signed by the facilitator at the end of each mindfulness session. Notes were kept in a binder at the school in an identified locked file cabinet. The facilitator of the mindfulness group took observational notes during and after each group. The collection of the group facilitator's observational notes (Appendix G) supports in understanding the participant's receptiveness to mindfulness as an Intervention. Following the 8-week group sessions, youth participants had an opportunity to review the facilitator's observational feedback for alignment and validity.

Data Analysis

The next section addresses the type of data analysis used for youth, teachers, and parents and the credibility and reliability identified for each sample group.

This explanatory case study involved a continuous interplay between data collection and data analysis (Raddon, 2008; Avidan, 2017; Strauss & Corbin, 1994). For this reason, data collection begin with the first interview with parents and teachers to start identifying characteristics associated with their student's ability to display self-control

and self-manage their emotions and behaviors when engaging in conflict or stressful experience (Evans & Lewis, 2018; Leedy and Ormrod, 2013; Thomson et al., 2017; Young et al., 2018). The process of data analysis in qualitative research involves creativity and intellectual craftmanship (Leedy and Ormrod, 2013; Raddon, 2008; Avidan, 2017; Strauss & Corbin, 1994). Avidan (2017) reminds qualitative researchers that "there is no particular moment when data analysis begins, analysis "he explains, essentially means taking something apart" (p.49), which in this case, not only meant understanding the real-life experiences of Hispanic adolescents with depressive symptoms engaging in mindfulness, but also identifying the characteristics that emerged from the data collection process from each stakeholder group involved in the study.

The two research questions for this study posed the question of "Characterization," which was the main product of data analysis for this explanatory case study; for that purpose, we used Thematic and Propositional analysis to corroborate aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms (Leedy and Ormrod, 2013; Braun and Clark, 2006). ***Thematic Analysis*** Thematic analysis was essential in outlining trending themes that emerged from the data collection of this explanatory case study, which consist of parents, teachers, facilitator, and youth. Using four sample groups to collect data supported the researcher in providing a holistic perspective that supports exploring the real-life experiences of adolescents with depression or depressive symptoms engaging in mindfulness as an alternative intervention tool (Hughes et al., 2017). The process involved identifying themes through "a careful reading of the data" (Braun and Clark,

2006; Nikitas et al.,2019; Evans & Lewis, 2018). It is a form of pattern recognition within the data, where emerging themes became the categories for analysis (Nikitas et al.,2019; Evans & Lewis, 2018). According to Evans & Lewis (2018), using thematic analysis is a sophisticated qualitative tool. Thematic analysis was helpful to support in a precise, consistent, and exhaustive manner through recording, systematizing, and disclosing the methods of analysis and the study results with enough detail to enable the researcher to promote the credibility and validity of the process. Thematic analysis has been used extensively in transport research (e.g., Chapman and Musselwhite, 2011; Farber et al., 2018; Fishman et al., 2012; Gössling et al., 2016; Hafner et al., 2017; Nikitas et al., 2019), producing robust results. To answer the questions "how" and "why" mindfulness may benefit Hispanic adolescents with depression or depressive symptoms a thematic analysis method that was inspired by Braun and Clarke's (2006) six-step approach was utilized:

(1) getting familiar with the data through transcription

(2) generating initial codes

(3) searching for themes

(4) reviewing themes

(5) defining and naming themes

(6) producing the final written output

(Braun and Clarke's, 2006; Hughes et al., 2017; Nikitas et al.,2019). This form of analysis supported in ensuring that throughout the analysis, the extraction and

interpretation of findings were based on the raw data rather than on the researcher's impressions (Braun and Clarke's, 2006; Hughes et al., 2017; Nikitas et al.,2019).

Propositional Analysis: Identifying Propositions

A propositional analysis was used to match findings against the propositions addressed for this study (Yin, 2013). The integration of mindfulness practices in the clinical settings using Mindfulness-Based Stress Reduction (MBSR) for patients with chronic pain corroborated Kabat-Zinn J (1990) mindfulness intervention model evincing:

- Significant change related to positive characterization shifts associated with the program's model primary focus toward self-regulation of stress, anxiety, and depression
- Significant acceptance towards the model curricular activity associated with foundational understanding toward reflective strategies, collaborative discussion, and a peer support approach

Some alternative propositions that disputed or extended Kabat-Zinn J (1990) mindfulness intervention model shows:

- Continuing or evolving characterization of the focus of the program acts as an isolated psychotherapeutic treatment
- Continuing or evolving characterization of the focus of the program's facilitator presence as co-dependent

NVivo Software

NVivo software helped to sort, code, and retrieve the qualitative data acquired through archival documents, semi-structured interviews with teachers and parents, and

youth adolescent mindfulness group reflective documents. Integrating Nvivo software was a compatible application for thematic analysis due to the nodes providing a simple structure for creating codes and discovering themes (Zamawe F. C, 2015). The automated tool for analysis created an easy, effective, and efficient coding process which made retrieval of data analysis less time-consuming than manual qualitative data analysis applications (Zamawe F. C, 2015).

Issues of Trustworthiness

For this explanatory case study, data was collected from multiple sources to triangulate information, which supported building a complete picture of Hispanic adolescents with depression or depressive symptoms experiences with mindfulness. Interviews, archival analysis, and reflective field notes from the mindfulness group was used in the triangulation process to gain a holistic qualitative perspective (Bowen, 2009). The researcher was aware that qualitative data collection incorporates interpretation of the text as its basis, which can formulate multiple meanings (Evans & Lewis, 2018). However, the validity of qualitative research was shaped through the lens of the researcher and participants (Monshat et al., 2013). Given the background of the researcher and the foundation of mindfulness employed in the school environment utilized for the study, there was a shared understanding preestablished. Having a shared experience of mindfulness that was rooted in Kabat-Zinn's conceptualization was essential for this study.

As part of the recruiting process, a demographic survey was administered to identify foundational characteristics to determine baseline engagement in Mindfulness for

parents and adolescents. The survey provided the researcher with foundational knowledge about the participants and family, which assisted in the analysis interpretation of the data. Efforts were made to increase credibility, transferability, and dependability through the research design. The researcher provided transcript audio records of the semi-structured interviews conducted for parental guardians and teachers of adolescents participating in the study. The recorded audio was reviewed and transcribed to ensure accuracy and descriptive validity. At the end of 8-weeks, the researcher provides participants with the facilitator's interpretation of their reflective notes, including trends and themes named; these notes were shared with participants with a summary of the findings for review and commentary.

Ethical Procedures

Once approval was granted by the IRB for engagement in the study the researcher called the site administrator to review study process and answer questions. Following the conversation with the site administrator a letter was sent to the site administrator (Appendix A) to inform that the study would begin the recruitment process. Along with the site letter, an email was sent to the counselors at the local school of choice to begin process to identify participants for the study using the inclusion criteria.

Informed consent was collected from the parent/guardian and teacher of youth engaged in the case study. Informed consent included the potential benefit, harm, and the participant's rights to opt-out of the study at any point without consequence. Although youth were informed of the study’s criteria and general overview, no official informed consent was needed as the researcher collected data through teacher/guardian interviews,

reflective notes, and archival analysis (Yin, 2013). Data collection took place in three forms: interviews, document analysis, reflective notes. Below, the collection type and confidentially procedure for each collection type are described.

Semi-Structured Interviews

To protect confidentiality and anonymity of the Parent/guardians and teachers participating in the study, mask identity was captured on all forms or documents collected or recorded. Parent/Guardian and Teacher were identified by numerical descriptors (*teacher 1, Parent/guardian 1*). Interviews were schedule prior to the meetings, asking for 30 minutes between the hours of 7:00am – 6:00pm, which aligned with the school personnel building hours. Interviews took place by either team's virtual call or phone call. All interviews were recorded using "Otter" as a recording tool. Parent/Guardians and teachers did not receive incentives for engaging in interview process. Parent/Guardian and Teachers were reminded that they may quit the study at any point, and if feeling of distress arise during the interview process, a counseling service number would be provided for personal use. The interview recording was stored on a password protected application and the research is the only person that had access to the login information.

Archival Analysis: Student Reflective Notes

Approval from the school to conduct this study included access to student information including, grades and behavioral reports, on a weekly basis during an 8-week period when the study was conducted. Student information was only reviewed by the researcher and kept with the weekly documents obtained that were housed with the site administrator in a locked file cabinet on campus. Reflective notes were confidential and

only reviewed by researcher for analysis purposes. To protect confidentiality and anonymity of the youth participating in the study, mask identity was captured on all forms of documents collected or recorded. Youth were identified by numerical descriptors (*Youth 1, Youth 2 etc.*). Youth descriptors were matched with parent/guardian and teacher descriptors for researcher's alignment of student findings. No real location was identified on any documents, the location descriptor was described as school 1.

Following the 8-week group session, youth participants had an opportunity to review the facilitator's reflective feedback for alignment and validity. However, district and school personnel only gained access to the complete findings associated with thematic trends of the study. The confidentiality of the reflective notes ensured that the student participants had a safe and nonjudgmental enviornment to express themselves to their highest potential. The reflective and notes for this study were signed by the facilitator at the end of each mindfulness session. Reflective notes were kept in a binder at the school are stored in an identified located file cabinet at the school to ensure all materials were housed in one place.

Archival Analysis: Facilitators Reflective Notes

Mindfulness sessions were confidential, and no outside parties were present during the weekly session. Reflective notes were pre-determined, and the group session structure was consistent to offer participants familiarity throughout the 8-week process (Appendix G) Each group session had the following components: meditation, mindfulness practice, independent reflection, whole group discussion.

Following the 8-week group session, youth participants had an opportunity to review the facilitator's written notes for feedback to contribute to alignment and validity. However, district and school personnel only gained access to the complete findings associated with thematic trends of the study. The reflective notes for this study were signed by the facilitator at the end of each mindfulness session. Notes were kept in a binder at the school and stored in an identified located file cabinet at the school to ensure all materials were housed in one place. At the completion of the study all documents were transferred from school to researcher’s home office. A copy of research findings was presented to school counselor, administrators, and district contact person at the completion of the study for review. Data collection will be destroyed on or before 5years has passed from the completion of the study.

Summary

Chapter 3 contains: (a) qualitative explanatory case study method for Hispanic adolescents engaging in Mindfulness Interventions to dispute or extend aspects of the model for adolescents identified with depressive symptoms in urban settings in Southern U.S, (b) a solid methodology framework to address the topic of inquiry created through interviews, document analysis, informed consent, issues with trustworthiness, and potential research bias. Chapter 4 provides the study results.

Chapter 4: Results

This chapter contains the results of an explanatory case study conducted to answer the following research questions:

RQ1: How do stakeholders characterize MIs for Hispanic adolescents, ages 14- 18 with depression or depressive symptoms in urban settings?

RQ2: Do participatory characterizations corroborate, extend, and/or dispute mindfulness as an alternative psychotherapy treatment tool for Hispanic adolescents with depression or depressive symptoms in urban settings?

This study was focused on Hispanic youth ages 14-18 with depression or depressive symptoms engaging in a school-based MI. Mindfulness practices such as meditation and reflections were an essential element in the study's model (Khoury et al., 2012) along with consistent weekly connections based on Kabat-Zinn (1990) 8-week program structure. Four youth along with their parents, teachers and a group facilitator were participants in this study. The study was conducted using semi-structured interviews, facilitator reflection and student reflection. The analysis has been done using thematic and propositional analysis and the results have been identified through key themes presented throughout this chapter.

This chapter includes the following sections: (a) setting, (b) demographics, (c) data collection, (d) data analysis, (e) evidence of trustworthiness, (f) results, and (g) summary.

Setting

The study was conducted at a single urban high school located in a Southern U.S. community from March 2022 to May 2022. Parent/guardian and teacher interviews were conducted via telephone or virtual setting between the hours of 11:00am and 6:00pm. During the time of the interview, no other parties were present. Facilitator and student reflections were captured at the completion of the one-hour mindfulness group session. The mindfulness group session is a weekly based session that happens each Friday and is a standard part of this school operating structure. When school is not in session on Friday, the mindfulness group facilitator has the option of adjusting the weekly date to meet the weekly commitment.

During the time of the study there were no personal conditions that influenced participants and their experiences. However, an organizational condition that influenced the participants and their experience at the time of the study was related to the COVID-19 pandemic safety measures that were still prevalent during the time of the study. The school and the study criteria allowed for face to face interviews with teachers; however, all teacher participants preferred to meet virtually as a safety precaution. When originally speaking to teachers about setting up interview time and preference of location, all teacher participants stated that they felt more comfortable meeting virtually as a safety precaution following the COVID-19 pandemic.

Demographics

This study accessed stakeholders and records about four Hispanic youth with depression or depressive symptoms. The participants of the study included four youth, the

parent/guardians, teachers, and one mindfulness group facilitator. The youth participants who engaged in the weekly school-based mindfulness group were between the ages of 14 and 18 years old. Two of the youth participants identified as female and two identified as male. To maintain confidentiality the only demographic information identified was related to the inclusion criteria and no additional demographics about participants were collected.

Data Collection

An explanatory case study was appropriate in gathering data to determine how and why implementing MIs are an essential alternative psychotherapy intervention for adolescents with depression or depressive symptoms (Yin, 2013). The data collected includes details that produce specific feedback on parental, teacher, youth, and facilitators perspectives on the MIs implementation. Data were collected using multiple data collection forms, including semi-structured interviews through audio and transcripts and document analysis in the form of reflective notes (Yin, 2013). The next section highlights data collection of parent/guardian, teacher, facilitator, and Hispanic youth.

Table 5

Data Collection

Stakeholder	Participants	Instruments	Frequency	Location & duration	Data recorded
Parent/guardians	4	Semi-structured interviews	2	30 minutes/virtually	Otter application to record interviews and transcribe
Teachers	4	Semi-structured interviews	3	30 minutes/virtually	Otter application to record interviews and transcribe

Facilitator	1	Reflection	8	Weekly/ school	Using structured checklist document
Hispanic adolescents	4	Reflection	8	Weekly/ school	Using independent reflection document

The data collection process was aligned to the structure and format identified prior to the study execution and outlined in Chapter 3. However, there were areas of the data collection process that should be noted but did not change the structure of the research. One area was related to the interviews of the parent/guardian and teachers. When conducting the parent/guardian and teacher interviews and asking the five foundational questions for the research study, it appeared that the time limit identified was more than what was needed. When reviewing the time length for all interviews, identifying 15 minutes as a base for all interviews would have been an adequate time limit for this study.

Data Analysis

This single explanatory case study used thematic and propositional data analysis to corroborate aspects of the practice of Mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms. To answer the questions “how” and “why” mindfulness may benefit Hispanic adolescents with depression or depressive symptoms, the thematic analysis method that was inspired by Braun and Clarke’s (2006) was utilized:

(1) getting familiar with the data through transcription

(2) generating initial codes

(3) searching for themes

(4) reviewing themes

(5) defining and naming themes

(6) producing the final written output

(Braun & Clarke, 2006; Hughes et al., 2017; Nikitas et al., 2019). This form of analysis supported the extraction and interpretation of the findings by providing a clear outline in identifying themes based on the data collected from parents/guardians, teachers, facilitator, and students.

Data Coding

The first step after data familiarization was carrying out the initial coding. Four categories of data were uploaded: *Parent interviews, Teacher interviews, Facilitator reflections, Student reflections*.

Initial coding of the data resulted in creation of 1,713 auto codes which created a lengthy list of words that were used within the transcripts multiple times. This list provided a reference point for words with higher frequency, which served as a starting point for coding transcripts. The first list of codes was organized into groups to search and name themes. The aggregated codes were named and converted into themes. Themes were then organized according to the research question and supported by the text from transcripts. Themes were coded by overarching trends identified when reviewing data from all stakeholders.

World Cloud

Word cloud generated the frequency of most frequently appearing words in the transcripts. The word clouds helped to quickly understand the position of a word within the collection of all transcripts and presented in the output was a visual where the size of the words reflects the frequency of word reflected the frequency of word. Most frequent words reflected in the word cloud were *interviewer, teacher, like, know, feel, well, good, parent, student, think* etc. These words are most discussed words in the transcript in relation to the student reflection, facilitator reflection, teachers, and parent's reflections.

Figure 1

Word Cloud – All Transcripts

Thematic Analysis – Results

The codes were created by reviewing the data transcripts repeatedly and identifying the relevance and text reference associated with each code generated. The result of coding was six themes identified and arranged according to the sequence of the research questions: (1) Characterization of Depressive Symptoms, (2) Treatment for Depressive Symptoms, (3) experience and Engagement in Mindfulness Activities, (4)

Influence of Depressive Symptoms on Relationships, (5) Behavioral Changes after engaging in Mindfulness, and (6) Expressed feelings of Students.

Theme 1 - Characterization of Depressive Symptoms. Stakeholders' ability to characterize depressive symptoms was a key component in determining how MI impacted those symptoms over the 8 weeks. Therefore, during the demographic survey and first interview, parents were asked to share information about their student and the type of depressive symptoms that they were observing in the home. While parents were able to identify generalized depressive symptoms such as students feelings sad, hopelessness, loss of interest in activities, and frustration, parents also shared other experiences that enhanced their student's depressive symptoms. Parents identified traumatic incidents that had taken place in the last 6 months that they felt enhanced their student's depressive symptoms, which included the death of a parent or relative.

In the interview, Parent 1said, "He didn't get the opportunity to go to this funeral because it was in Mexico. And everything just happened so quick. So, he really did have a chance to say goodbye to my dad. And it's been very tough."

Parent 4 said, "She did have something happened; her dad got murdered."

These traumatic experiences enhanced certain depressive symptoms, such as sadness, irritable behavior, lack of sleep, poor eating routine, less interaction with family and friends, poor academic performance, and crying.

Teachers 4 said she is "tired often, like sometimes she'll have a mark on her forehead from where her arm was last period. And she will say that she took a nap in last period."

Theme 2 – Treatment & Support for Depressive Symptoms. Medication for depressive symptoms was being used by one student during the time of the interviews; however, the other three parents had knowledge about medication management and choose to manage the symptoms without use of medication. One parent reported that her student loss of appetite was a symptom of his depression that triggered her to take him to the doctor. After being diagnosed with depression, he was prescribed medication. However, she noticed a continued decline in his appetite that resulted in weight loss. After 1 year with no significant change in his behavior and the constant weight loss, she stopped the medication. Parent 3 said, “With the medication that kind of like takes away his appetite even more.”

The four parents in the study expressed that once they were given information about their student’s depressive symptoms or diagnosis that they became more communicative with teachers about their student’s needs. There communication created a pathway of intentional support for their student and students received additional support for their depressive symptoms at school by their classroom teachers. Teachers shared that they would accommodate the classroom environment to support the student’s needs. Those accommodations included: seat change, individual check-ins, and one on one guidance in classwork. Students with depression symptoms found it difficult to complete classwork, and in this situation, teachers encouraged them to try and to complete as much work as possible in those moments Teacher 4 said, “1-1 check-ins and allowing her to do the group work by herself and letting her know that if she needs to talk to one of the therapists that she is able to she can always catch up on work later.”

Teacher 2 said, “If it’s like a really bad day, sometimes we’ll talk about like, what is the minimum we can do in this day and like when can we catch up on the others?”

Furthermore, support for students with depressive symptoms were also associated with the student’s interest. Parents expressed that finding moments to support their student engaged in lighter activities and personal joy was an essential component in bringing positive moments to their student’s home life. Personal joy for students at home often looked like sleeping, video games or reading books. Parent 3 said, “He usually plays like video games with his friends.” Parent 4 said, “She doesn’t really like doing much besides, just like reading books and going to the bookstore.”

Theme 3 - Experience and Engagement in Mindfulness Activities

Engagement in mindfulness activities is referred to treatment like meditation, exercise, reflection, and yoga. While parents were not able to identify observing their students engaged in a distinguished mindfulness activity like meditation, surprisingly they were able to identify other activities that the student would engage in that presented moments of stillness or personal reflection. Students were finding more moments to engage in self-driven activities more often.

Parent 4, said, "No, not really. I mean, she doesn't really like doing much besides, just like reading books and going to the bookstore and like going through shopping and we do that she doesn't choose to like to do that”.

Mindfulness activities come in various forms and for one family it came in the form of boxing. one parent felt that their student needed a new way to release their feelings due to increased stress at home due to parental separation. This parent begins to

engage in boxing and enrolled all of the children with the belief that it helped to release frustration, anger, and negativity by punching the sandbag. This parent felt that with their child's depressive symptoms and the separation that new ways to release was imperative to supporting her child's ability to process the new family dynamic.

Parent 1, said, "I did have all my kids in boxing while we were going through the separation process, and we would take walks and just keep our minds going".

Mindfulness activities typically start at the foundation, which typically is comprised of yoga and meditation. However, the more experienced that is associated with the facilitator and/or practitioner, the more creative approach can be offered. For this study, among the teachers and parents, one parent and four teachers had previous experience of engagement in mindfulness activities. Teachers showed more experience with the foundations of mindfulness compared to parents. Teachers were able to use language associated with mindfulness practices such as meditation, yoga, journaling. Whereas parents expressed limited engagement in mindfulness and shared experiences where mindfulness was present such as boxing, walking, journaling.

Teacher 2, said, "I meditate daily each night before bed. During times of great stress, I also meditate in the morning and, at times, throughout the day. I love listening to guided meditations on my phone; I use the Insight Timer app. Sometimes I do yoga and I often go for walks to clear my mind".

Teacher 4, said, "Yes, Meditation. I engage in therapy. I have started journaling with students in class. I have also tried meditation in class, but anything longer than a minute doesn't really work"

Theme 4 - Influence of Depressive Symptoms on Relationships

The influence of depressive symptoms on relationships with family was evident with the relationship with student with depressive symptoms and sibling relationships. Sibling relationships presented irritation and combat at times in the home environment that increased overtime. What would be described as developmentally normal sibling rivals were elevated by the student's depressive symptoms, which presented conflict with their siblings. These conflicts increased overtime as they were not present in previous years.

Parent 4, said, "No not physical, she will be telling her sister to shut up if her sister is just singing or playing, she'll tell her like, shut up".

Parent 3, said, "He just annoys his little sister, but I can tell he really cares for her like, he won't hurt or anything. He'll just mess with her a little".

While the home environment presented challenges with siblings, teachers and parents felt that even with depressive symptoms that their student was able to communicate with them about how they were feelings and what they needed.

Parent 2, said, they have been open about everything, and they told me that they are grateful to be able to communicate with me and that, you know, we do not really sugarcoat anything.

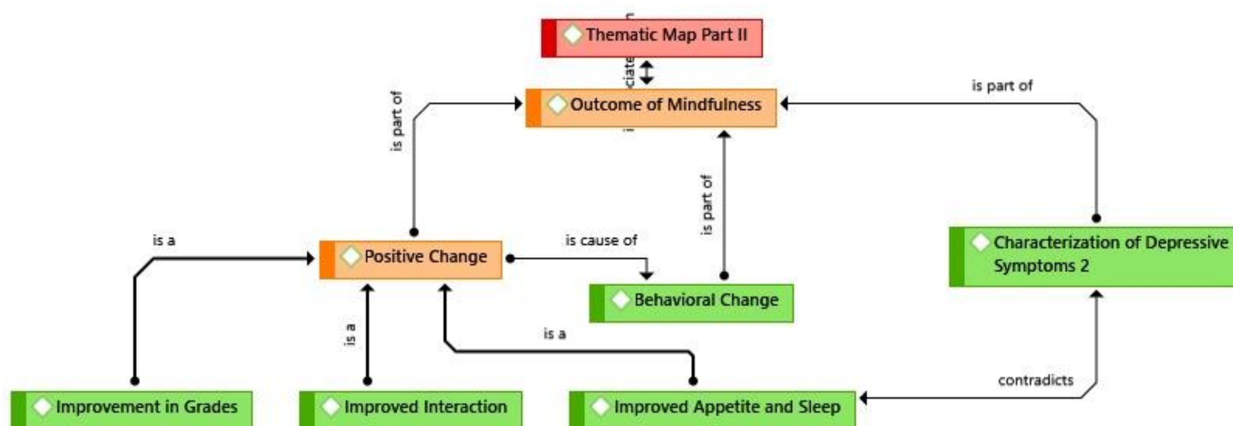
Teacher 4, said, "I think it has influenced our relationship positively because I often see students who seem to have some symptoms of depression, but they aren't able to speak about what they are going through. They are not able to advocate for themselves".

Theme 5 - Behavioral Changes after engaging in Mindfulness

After collecting data for 8-weeks through archival records, reflections and interviews the results showed that students exhibited positive changes in behaviors including improved grades, interactions, appetite, and sleep, which led to an overall improvement in the personal routines and academic performance. During the post intervention interviews participants shared that they felt their student's depressive symptoms were reduced due to direct behavioral changes in mood and interaction.

Figure 2

Thematic Map – Mindfulness Outcomes



Teacher 1, said, "I would generally characterize his behavior as being more on the upbeat".

Teacher 3, said, "He improved a lot on his grades too, so he is pretty focused in school as far as I know."

Through the 8-week intervention engagement, the confidence of students was enhanced. Parents and teachers reported that students were thinking about bigger goals and aiming at high targets, increased interaction with other students and improvement in grades were the clear signs of positive change.

Parent 3, said, “I think right now; I think he's doing a lot better. I mean, he is still down. I know that but I think that the key thing has been to show him that we love him. I guess it helps him get out of the funk”.

Teacher 3, said, “it was I sat down with him we noticed that he likes to lead he likes to, to do things, like big things, you know, and he likes to like, get other people involved and stuff like that. And we noticed that when he does that, those things. He's like, his mood changes, I guess, because I mean, he's doing something that he really likes, you”.

The interventions supported adjusting the student’s mood into pleasant and consistent. Their behavior with other family members and schoolmates was greatly improved in terms of talking and interacting with others. Some students displayed a more introverted personality, therefore they preferred to stay reserved and performed well independently.

Teacher 1, said, “Pretty consistent, pleasant. You know, we greet each other every morning, you know, he greets me back. You know, he interacts with his peers a little bit”.

One surprising encounter was related to student 4 who typically appeared to be extremely emotional when entering class as evident by crying spells and refusal to enter the classroom and requesting meetings with counselor. This behavior resulted in limited completion of classwork as the teacher typically involved counselor to defuse the emotional escalation. However, during the 8-weeks of implementation of mindfulness the teacher noticed that the students was making more of an effort to enter the classroom and less request for the counselor. The student appeared to be using independent coping

strategies like working independently or taking two to three minute breathes outside the classroom door prior to entering.

Teacher 4, said, "Recently, she's been wanting to do more independent work rather than work with anyone else."

Students showed positive changes in terms of academic performance and improvement in their grades. It indicated that the depressive symptoms were eliminated or reduced in the classroom enviornment and they can concentrate on their academic tasks.

Parent 3, said, "He actually has been doing good right now. He's been very active with a program that is in for like scholarship and stuff".

Teacher 1, said, "He is currently passing. He does have a few missing assignments, but he's passing the semester".

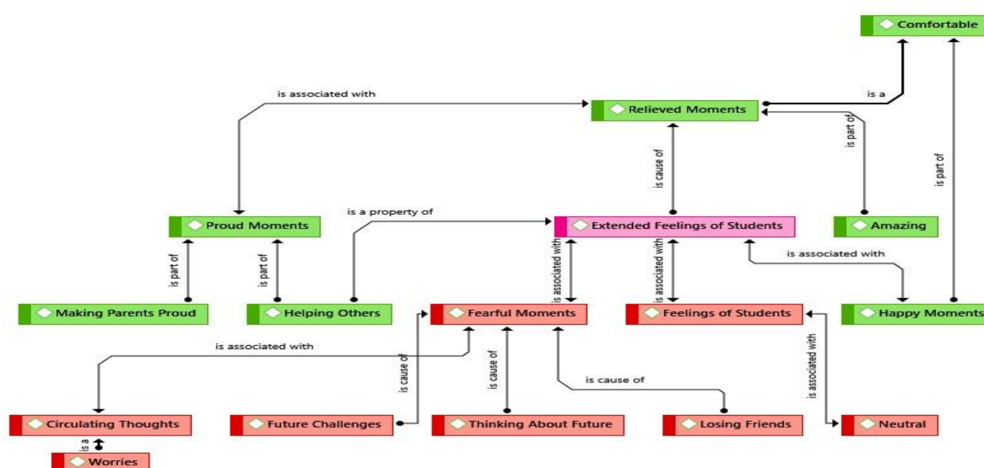
While engaging students in mindfulness activities, no resistance was observed with student engagement from week to week, and they were willing to take part in all sessions.

Theme 6 - Expressed feelings of Students.

The feelings of the students were noted during their self-reported reflections from week 1-8. The pattern of words they shared during these reflections showed a gradual improvement in the feelings and expressing feelings.

Figure 3

Thematic Map – Expressed Feelings



The students extended feelings were reflected in their independent reflection documents by asking them different questions each session. These questions were open ended and related self-discovery and emotional regulation. The text was analyzed to identify initial codes, grouping of initial codes and formation of single group and naming as the extended feelings of the students. Twenty-one sub themes in this category were coded according to the questions asked to students while the initial codes were extracted from the responses to those questions and based on the words and phrases from the selected text. The answers contain their feelings and reflections of the situation they are undergoing. Key elements identified from the text reflected in-depth feelings of the students and are outlined in Annex B: Extended Feelings of Students

Propositional Analysis – Results

For this explanatory case study, we corroborated aspects of the practice of mindfulness as a treatment intervention for Hispanic adolescents with depressive symptoms (De Vibe et al., 2012; Gouda et al., 2016; Khoury et al., 2013). Therefore, the propositional analysis was corroborated by matching findings against the propositions addressed (Yin, 2013). There were two propositions based on the integration of mindfulness practices in the clinical settings using MBSR for patients with chronic pain to corroborate Kabat Zinn J (1990) mindfulness intervention model.

The first proposition stated, significant change related to positive characterization shifts associated with the program's model primary focus toward self-regulation of stress, anxiety, and depression. The study results showed significant changed related to positive characterization shifts after the implementation of the 8-week mindfulness group from teachers and parents.

Teacher 1, said, "I think he's doing a lot better."

Parent 3, said, "his mood changes, I guess, because I mean, he's doing something that he really likes, you".

The second proposition stated significant acceptance towards the model curricular activity associated with foundational understanding toward reflective strategies, collaborative discussion, and a peer support approach. The study results showed significance change in student interaction with peer.

Teacher 1, said, "You know, he interacts with his peers a little bit sometimes gets off track and off task".

There were no direct quotes regarding reflective strategies or collaborative discussion. Weekly sessions and feelings reflected through words showed a positive word association with student entry and exit from mindfulness group session weekly.

Table 6

Weekly Sessions and Feelings Reflected Through Words

Students	**Weekly Sessions and Feelings reflected through words**							
	Week-1	Week-2	Week-3	Week-4	Week-5	Week-6	Week-7	Week-8
1	safe and relived Peaceful	Ok Amazing	Ok Amazing	Ok Amazing	Neutral Amazing	Bad Ok	Neutral Ok	Ok Amazing
2	Ok Amazing	Neutral Ok	Slow day Weekend work	Bad Good	Ok Amazing[1]	Ok Amazing	Good Amazing	Good Amazing
3	Ok Amazing	Ok Amazing	Terrible Ok	Ok Good	Ok Ok	Good Amazing	Ok Good	Absent
4	Bad Ok	Ok Neutral	Neutral Ok	Ok Ok	Ok Ok	Absent	Absent	Terrible Ok

Note. Ratings retrieved from four Hispanic adolescents during the eight-week student window.

NVIVO Software

NVIVO software was used as the database to support in sorting and coding the data collection of archival documents, interviews, and reflections. Using NVIVO software helped to identify and determine codes, summaries, word frequencies, word clouds reports, and cluster analysis (Zamawe F. C, 2015). After reviewing the initial auto codes, creating cluster categories, and determining the frequency of words used throughout the transcripts, the data themes began to be apparent and manual codes were

created in the software. The simplicity in the transcript coding structure provided through the NVIVO software was an essential component in clearly identifying themes that emerged through the data. After creating the first set of codes, the process of compiling similar codes into thematic categories was an efficient process and resulted in the six thematic themes identified for this study (Zamawe F. C, 2015).

Evidence of Trustworthiness

For this explanatory case study, data was collected from multiple sources to support triangulation of the information. Triangulation was an essential component to the credibility of the study's findings and provided a holistic understanding of the experiences of Hispanic adolescents engaged in mindfulness as an intervention for depression or depressive symptoms (Bowen, 2009). Collecting data from interviews, document analysis, and reflective notes from varies stakeholders allowed themes to emerge from the data that represented the collective views, which provided a clear perspective for Hispanic adolescent's engagement in mindfulness as an intervention mode (Evans & Lewis, 2018; Monshat et al., 2013). While, this study did not aim for replicability additional efforts were made to increase transferability, confirmability, and dependability, including transcript audio recording of the semi-structured interviews for parent/guardians and teachers. The recorded audio was reviewed and transcribed to ensure accuracy and descriptive validity. At the end of the 8-weeks, participants reviewed the facilitators interpretations of their reflective notes to confirm trends, themes and share any additional commentary.

Summary

The first research question for this study was related to "how" stakeholders characterized mindfulness interventions for Hispanic adolescents, ages 14-18 with depression or depressive symptoms in an urban setting. Mindfulness activities are referred to as activities that include the following: meditation, exercise, reflection, and yoga (Rubens et al., 2018; Huq et al., 2016; Khoury et al., 2012). The results of this study showed positive attributes associated with mindfulness engagement from students with depression or depressive symptoms. After mindfulness interventions, parents and teachers reported that students exhibited positive changes in behaviors including improved grades, interactions, appetite, and sleep, which led to overall improvements in the personal routines and academic performance. Parents and teachers were also able to observe increased confidence in students, which led to students communicating life goals, interacting with peers, and having an increased sense of engagement in school. Furthermore, mindfulness supported adjusting student's mood into pleasant and consistent, which was observed with siblings at home and with peers during classroom activities.

Additionally, the study was also able to corroborate mindfulness as an alternative psychotherapy treatment tool for Hispanic adolescents with depression or depressive symptoms based on participatory characterizations results of the study. Student's self-reported reflection from week 1 to week 8 showed a gradual improvement in feels and expressed feelings based on word association and identification. Students showed positive changes in classroom engagement, which resulted in increased concentration on

academic task. Student engagement was met with receptiveness and students were optimistic about weekly sessions. Chapter 5 contains (a) interpretation of findings (b) limitations of the study (c) recommendations, and (d) implications.

Chapter 5: Discussion

Introduction

The purpose of this study was to corroborate aspects of mindfulness practice as a treatment intervention for Hispanic adolescents ages 14-18 with depressive symptoms. Depression and depressive symptoms are prevalent in the Hispanic youth population, as evident by 10.6% of Hispanic youth being diagnosed with depression and 10.8% experiencing depressive symptoms (Kroning & Kroning, 2016; Naicker et al., 2013; Werner-Seidler et al., 2017). However, despite the percentage of Hispanic youth being diagnosed with depression or experiencing symptoms, utilization of mental health services shows underrepresentation for Hispanics (McCord, 2017, Motjtabaii et a., 2016). Therefore, the discrepancy between the need for mental health services for Hispanics and the use of services called for an increased understanding of mental health services that support culturally relevant interventions. This study was conducted to address MIs as an alternative treatment option for Hispanic youth and explore real-life phenomena to answer *how* and *why* implementing mindfulness practices can be an essential alternative psychotherapy intervention for adolescents with depressive symptoms (Yin, 2013).

The study results corroborated that mindfulness as an intervention for Hispanic adolescents with depression or depressive symptoms showed positive attributes over time. The results also showed that positive attributes were visible to parental figures and teachers and that positive behavioral changes were associated with improvements in the adolescent's grades, interactions, appetite, and sleep based on self-reported findings identified from archival documents and interview notes. Information highlighted in

Chapter 5 includes a detailed breakdown of the following sections: interpretation of findings, limitations, recommendations, implications, and conclusion.

Interpretation of the Findings

I conducted this study to answer two questions about the lived experiences of Hispanic adolescents with depression or depressive symptoms engaging in mindfulness as an alternative psychotherapy treatment tool. The research questions were grounded in the “characterization” component that would support the study in highlighting specific behaviors and experiences associated with their engagement in mindfulness. Determining “how” stakeholders characterized the experiences of Hispanic adolescents, and discovering the participatory characterization of the Hispanic adolescents, resulted in a wealth of narrative knowledge that led to findings that confirmed and extended knowledge about alternative supports for Hispanic Adolescents with depression or depressive symptoms.

Data were collected from four stakeholders (parent, teacher, student, and facilitator) to provide a holistic understanding of the adolescent’s experience when engaging in the mindfulness 8-week group structure. My framework was grounded in the MBSR model developed by Kabat-Zinn 1990, to support clients dealing with chronic pain. The MBSR approach was popularized in western culture as clinical practice in hospital settings to allow clients to embrace their symptomatic responses and illness diagnosis directly without judgment of their experience (Dryden & Still, 2006; Segal et al., 2012). The opportunity to support clients in embracing their present experience with their health conditions was intriguing to other areas of medicine, and the MBSR core

curriculum was incorporated into MBCT to prevent relapse in adults with previous depression (Segal et al., 2012). Although the core curriculum has been altered over time, components of the curriculum are foundational, including an 8-week approach, meditation, and reflection. For this study, the research remained consistent by incorporating the foundational components of the MBSR framework.

Mindfulness as an Intervention

MBSR and MBCT supported the increase of mindfulness practices in clinical and mental health settings between 1970 and 2000. However, participants engaging in mindfulness were primarily White, female, and middle-to-upper-middle class (De Vibe et al., 2012; Segal, 2012; Khoury et al., 2013; Park et al., 2015). Previous studies reported engagement in mindfulness resulting in emotional and cognitive stability over time (Khoury et al., 2012; Segal et al., 2012) with improvements in sleep, confidence, self-regulation, and awareness (De Vibe et al., 2012). The study results corroborated similar findings for this study with Hispanic adolescents aged 14-18 with depression or depressive symptoms. Teachers and parents of the adolescents who engaged in the 8-week study reported positive characterization shifts associated with mood, stress, and energy levels.

Furthermore, the 8-week model approach provided adolescents with a weekly reflective moment, collaborative discussion, and peer support. I believed that the mindfulness group setting would be appealing due to the associated cultural norm of having a collectivistic worldview in Hispanic communities and promoting motivation and positive peer relationships (Mullen S, 2018; Rubens et al., 2018; Velasco-Mondragon et

al., 2016). This idea was corroborated over 8-weeks as adolescents in the group positively engaged in peer interaction and made efforts to connect with peers in classrooms through class activities and groups.

Stakeholders Characterization (Parent and Teacher)

People in direct contact with an adolescent experiencing depression or depressive symptoms are an essential supportive factor (Mullen, 2018; Rubens et al., 2018; Velasco-Mondragon et al., 2016). Adolescents spend 90% of their day interacting mainly with a parent/guardian, teacher/staff member, or peer. However, parent/guardian and teacher/staff member are trusted adult figures who can observe behavioral changes such as depressive symptoms. Their ability to characterize student behaviors is a critical component in determining treatment and best support for the adolescent (Mullen, 2018; Rubens et al., 2018; Velasco-Mondragon et al., 2016). Adolescents tend to self-medicate with drugs or alcohol rather than communicate with a parent/guardian, teacher, or professional (O'Conner et al., 2008; Vanghn-Coaxum et al., 2016; Velasco-Mondragon et al., 2016). Parents/guardians noticed irritability, lack of sleep, poor eating routines, less or combative interaction with family and friends, and poor academic performance. However, although these symptoms were noticed, parents felt that even with doctor visits and prescribed medication, it did not appear to be an effective treatment option as the student's symptoms often stayed the same. However, the intentional support from classroom teachers appeared to be a bright spot for teachers' ability to support students on campus. Teachers expressed that seat changes, individual check-ins, and academic

support were critical in the student's ability to cope with depressive symptoms and succeed academically.

Additionally, this study identified that while parents did not directly experience their child engaging in typical mindfulness activities (meditation, reflection, yoga) during the 8-week study, parents could begin to identify activities that their children engaged in that created personal enjoyment and moments of personal satisfaction. The application of mindfulness was presented in the student's ability to apply personal reflective moments that was practiced in their group session in their home-life. Students heighten self-awareness and deeper personal connection to themselves allowed them to be more confident about what they needed and how they wanted to be supported. While the practice of mindfulness involves exercises like meditation, journaling, and yoga to support moments of stillness and deep reflection, applying mindfulness in your everyday life may show up differently. For these students the application of mindfulness allowed them to identify self-driven joyful activities, enhanced their ability to communication, and created a sense of confidence and self-awareness.

Furthermore, prior to the 8-week study, parents were not able to communicate with their student about activities and hobbies. However, during the 8 weeks, parent's ability to identify activities their child enjoyed created opportunities for parents to support those activities and seek resources that supported them, which supported the adolescent's positive connection to home and family. Furthermore, communication was a heightened experience between adolescents and supportive structures. Parents and teachers felt that even in the presence of depressive symptoms, communication about

how the adolescent felt and what they needed was a positive characterization component and allowed them to provide direct and intentional support.

Participatory Characterization (Hispanic Adolescents)

Participatory characterizations were corroborated by the four Hispanic adolescents who engaged in the weekly mindfulness group sessions. The student's self-reported reflections showed a gradual improvement in their expressed feelings when entering and exiting the group session from week to week. The intervention contributed to students' adjusted moods being more pleasant and consistent when actively engaging with their family members and classmates. While students were not directly noting meditation or a specific mindfulness activity associated with improved feelings, they were able to identify that having a moment of reflection contributed to them being able to reflect on how they were feeling from week to week. These weekly touch point moments resulted in positive classroom engagement changes, which increased concentration on the academic task. Depressive symptoms were seen less in the classroom environment over the eight weeks as students reported being able to concentrate more on academic tasks and eliminate internal and external distractions more quickly.

Additionally, student engagement was met with receptiveness, and students presented optimism about engaging in the weekly session. One aspect of the weekly session that appeared to be a highlight for students was personal reflection. Students were able to share real-life connections to the prompts and how those experiences impacted them currently and in the future. During the personal reflections, moments of revelation and connections appeared in the students writing. The reflection questions encouraged

them to consider their emotional capacity, future goals and ambitions, and personal values. These thought-provoking questions lead to students' emotional ratings showing consistent improvements from their beginning rating throughout the 8 weeks.

Limitations of the Study

One of the limitations of a case study as a research methodology is the generalizability of the findings (Yin, 2014). This case study's purpose was not to determine the mindfulness model's effectiveness but to provide understanding associated with the theory of the mindfulness model, describing how the model works and why the model works with this specific population (Woolcock, 2013; Yin, 2013). Therefore, this study does not represent an optimal way to provide mindfulness as an intervention for program effectiveness and cannot be generalized beyond analytical value (Yin, 2013). I hope that the findings presented in the current study may inform future methodological or educational frameworks that can expand the scope or research about mindfulness for Hispanic adolescents, mindfulness for depression, mindfulness as an alternative psychotherapy treatment, MIs for school settings, specifically as viewed through the theoretical lens of MBSR.

Also, this study's methodology structure used several data collection types, including semi-structured surveys and interviews, archival analysis, and reflective notes. The facilitator's reflective notes are a limiting factor in the data collection. Although I explained the format and the documented outlined directions, the facilitator's notes did not provide as many descriptive findings about the semi-structured interviews and student self-reported reflections. The facilitator's reflection offered insight into the student

dynamic and classroom atmosphere during the weekly sessions. However, the facilitators focus was connected mainly to content execution and classroom management. This was an essential component to highlight as the students with depressive symptoms were engaging in this weekly session with other peers not having depressive symptoms, as this weekly session was a built-in component of the schools programming.

Another limitation was associated with a timeframe of data collection, which resulted in state testing taking place simultaneously as data collection. Data were collected during pre and post-testing season, which resulted in teachers and students preparing for the state test during the data collection process. This inevitable timing resulted in teacher stressors associated with time pressures, stressful workloads, and student disengagement. Teacher stressors were related to students' academic stressors during the testing season. Students reported in their reflections that a central area of concern was associated with test scores, final grades, and future career goals. Collecting data during the testing season may have impacted student and teacher's recollection of other stressors as the significant stressor associated with the testing season.

Lastly, several forms of mindfulness practices vary amongst practitioners based on experience. These study results were based on my experience and the methods of data collection and analysis I chose to employ. Other researchers would likely come up with alternative interpretations of the findings based on their approach and theoretical perspective associated with data collection and analysis methods. Therefore, this study highlights the essential role that the theoretical propositions associated with this case study (Yin, 2013, 2017)

Recommendations

Although MI has been associated with research studies for adults with chronic pain and depression, limited research has been conducted on minority culture groups, specifically, Hispanics that are adolescents engaging in mindfulness as an intervention to support depression or depressive symptoms (Fergusson & Woodward 2002; Fung et al., 2016; Schonert-Reichl & Lawlor, 2010; Segal, 2012; Khoury et al., 2013). Therefore, from the findings of this study, the following recommendations are to be considered for future research, mental health practitioners, and educators.

Parents and Teachers

The contemporary definition of mindfulness is “paying attention” on purpose. For this study, practicing paying attention on purpose was connected to the student's engagement with the weekly mindfulness activities. However, the act of parents and teachers engaging in a reflective moment through interviews throughout the 8 weeks presented an intentional practice for them. Therefore, the weekly interviews lead to parents and teachers being able to do the following overtime: (1) identify descriptive characteristics and behaviors that the adolescents were exhibiting in their presence, and (2) the ability to identify the stressors associated with supporting the adolescent.

Although parents and teachers did not engage in meditation or yoga, they reflected consistently with a consistent figure. This intentional moment with the researcher appeared to get more substantial over time and led to more in-depth responses from parents and teachers. I noticed that over the 8 weeks, parents’ and teachers’ ability to identify and characterize their student’s behaviors became more descriptive. Whereas

during the initial intake, parents and teachers took more time to describe and identify the characteristics of their students. A future recommendation for parents and teachers would be to increase the number of touchpoints with students with depression or depressive symptoms. Touchpoints may be associated with daily check-ins and intentional moments to connect with the student. Increasing the number of touchpoints may lead to parents' and teachers' ability to identify and respond proactively to students' behaviors.

Parents and teachers also reported stressors they were experiencing while attempting to support the adolescents, related to feelings of failure, helplessness, and tiredness. Future recommendations for parents and teachers would be to identify a self-care routine that supports managing their mental health and stress while supporting adolescents with depression or depressive symptoms. Parents and teachers may find it helpful to use mindfulness practices with the adolescent they support to increase their knowledge in practice. Engaging in mindfulness firsthand may lead to continued support and practices in the classroom and home life of the adolescent.

Mental Health Professionals

One risk factor for an adolescent developing depression includes peer conflict and peer pressure (Fung et al., 2016; Gouda et al., 2016; Werner-Seidler et al., 2017). However, a cultural norm associated with the Hispanic community is a collectivistic worldview. Therefore, engaging in the mindfulness group may have been interconnected between the adolescent's identity and their ability to understand the greater need for all adolescents to participate. This idea that their engagement and interaction was "doing what was best" may have contributed to their positive interaction and optimism in their

engagement. Nonetheless, adolescents with depression or depressive symptoms increased positive peer interaction over the eight weeks of engaging in mindfulness. A recommendation for mental health professionals and educators is connected to group formats when working with Hispanic Adolescents. Their internal connection to the group format and collectiveness may be a supportive factor for their individual need and group success.

Future Research Recommendations

There are still gaps in our knowledge about mindfulness being used as a treatment option for Hispanic adolescents with depression or depressive symptoms that follow from the results of this study and would benefit from future research, including the following:

(1) Understanding the perspective of mindfulness as a treatment option for Hispanic adolescents with depressive symptoms from a larger sample population. A mixed methods approach may help collect data from various schools across states.

(2) Using a qualitative approach to understanding the perspective of mindfulness as a treatment option for other minority culture groups, specifically African Americans.

(3) Using a qualitative approach, it may be helpful to capture the experiences and perspectives of teachers, parents, and students with mixed or negative experiences with mindfulness as an intervention.

Implications

The implications from the findings significantly corroborate the positive attributes associated with the mindfulness model and the possible outcomes for Hispanic adolescents with depression or depressive symptoms. Using the mindfulness model for

Hispanic adolescents with depression or depressive symptoms over eight weeks resulted in positive implications for practicing mindfulness as an alternative psychotherapy treatment option for depression. Due to mindfulness being added to their weekly regimen, Hispanic adolescents improved confidence, communication, peer interactions, and academic success. Furthermore, the school environment is a consistent place to offer additional support to students with mental health struggles (Fung et al., 2016; Gouda et al., 2016; Werner-Seidler et al., 2017). However, these students were identified as having depression or depressive symptoms, and the mindfulness group session was offered to all students as a weekly touchpoint. Proactive school initiatives that allow students to process stress and hardships and offer them a safe and non-judgmental space to engage in dialogue were essential for this study. Additionally, parents who engaged in the study shared positive feedback and engagement during the 8-weeks, which has the potential for more support to be offered to parents. The parental engagement was a crucial lever in this study and offered an intentional touchpoint to have parents reflect on their student's needs and support.

Mindfulness offers self-discovery and acceptance, directly impacting how a person shows up in their family and community. Therefore, positive social change is related to the continued exploration and support needed for Hispanic adolescents with depression or depressive symptoms. Creating programs and groups in Hispanic communities that will support their accessibility and engagement is critical in the widespread support for coping with depression and depressive symptoms. Program support from schools in those communities may help to spread language and knowledge

from a safe space, which will create a trickle-down approach to more offerings in communities.

Conclusion

Hispanic adolescents are vulnerable and underserved regarding mental health treatment options for depression or depressive symptoms (Mojtabaii et al., 2016; Potochnick & Perreira, 2010; Velasco-Mondragon et al., 2016). Mindfulness is not the only option, but it is a receptive response associated with positive outcomes (Chi et al., 2018; Huq, 2016). This study offered an opportunity to add to the literature by investigating “how” and “why” mindfulness intervention is a supportive structure for Hispanic adolescents with depression and depressive symptoms. This study showed us that although depressive symptoms were still present, with support and intentional touchpoints with all stakeholders, these adolescents were able to end their school year with a positive outlook. Their parents and teachers also shared a positive outlook that directly reflected their intentional focus and support over the last 8-weeks. Mindfulness is not just an alternative treatment option; it is a proactive practice that supports persons that may be symptomatic or fully diagnosed. The positive receptiveness to the model calls for continued exploration of mindfulness in Hispanic adolescents.

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Appendix A: Site Permission

Date:

The purpose of this letter is to inform you that I give Kierra McShine-Gregory permission to conduct a research study about the experiences of Hispanic adolescents with depression or depressive symptoms engaging in mindfulness interventions _to study the process and impact of mindfulness activities offered at Yes Prep Public School (Northbrook High School) as part of our standard operations.

The procedures for this study are the following:

- The student support administrative assistant will be responsible for sending email invitations to parents and teachers that meet the study's inclusion criteria.
- The researcher will have permission to use our school site to conduct one on one interviews with teachers if they choose to meet in person.
- The researcher will obtain permission from parent/guardian, student, and facilitator to view the student's and facilitator's weekly reflective notes.
- The facilitator will be the teacher of the weekly Friday restorative justice sessions.
- Parent/Guardian, Teacher, Facilitator, and Adolescent can choose to withdraw from the study at any point during the 8-week period.

This site permission serves as assurance that this school complies with requirements of the Family Educational Rights and Privacy Act (FERPA) and the Protection of Pupil Rights Amendment (PPRA) and will ensure that these requirements are followed in the conduct of this research.

I understand that the researcher will not be naming our organization in the doctoral project report that is published in Proquest.
I confirm that I am authorized to approve research in this setting and that this plan complies with the organization's policies.
I understand that the data collected will remain entirely confidential and may not be provided to anyone outside of the student's supervising faculty/staff without permission from the Walden University IRB.
Sincerely,
____Authorization Official
Contact Information:
_______________________________________ Phone
_______________________________________ Email

Appendix B: Inclusion Criteria

Participants in the study must meet the following criteria

Unit of Analysis	**Hispanic Youth**	**Teacher of Hispanic Youth**	**Parent/Guardian of Hispanic Youth**
Number of Participants	4	1	1
Criterion	Have seen a high school counselor at least twice for depressive symptoms Enrolled in high school	teacher of record	Legal Parent/guardian English speaking

Appendix C: Student Assent Form for Research

Hello, my name is Kierra McShine-Gregory and I am doing a research project to learn about "The experiences of Hispanic adolescents with depression or depressive symptoms engaging in mindfulness interventions". I have chosen your campus because of its work with mindfulness. I am inviting you to share your perspective with my project, and I want you to learn about the project before you decide if you want to be in it.

Who I Am:

I am a student at Walden University. I am working on my doctoral degree.

About the Project:

This study involves the following steps over an 8-week period:

- Interviews with 4-6 parents/guardians
- Interviews with 4-6 teachers
- Reviewing individual reflective notes from facilitator and students

Students notes will include the following sections:

- Emotional Rating: *how are you entering the space on a scale of 1-5*
- Note Take Section: *what are your thoughts about the session topic*
- Journal Prompt Section: *a mindfulness prompt to reflect on prior to leaving the space. Some example questions are*
    - What is your happiest moment of life?
    - Write down everything that inspires you,
    - Make a list of 10 things that make you smile.

Confidentiality & Privacy

- The researcher is the only person that will review your reflective notes
- Your name and school will never be released to the public.
- Once the study is complete, your parents will have access to the results and may review with you at that time.
- The only time I must tell someone is if I learn about something that could hurt you or someone else.

Voluntary:

You do not have to be in this project if you do not want to, and everyone involved will respect your decision to not be a part. You will be treated the same as any other student on campus. If you are ok with being a part of this project, you can still change your mind later. You may stop at any time.

If you identify yourself as a volunteer, I will then gain access to your reflective notes after each session and the teacher of the session will give me your notes to review. I will not share your responses with any other person.

Being in this project might make you tired or stressed, just like any school activity. But I am hoping this project might help others by understanding how students respond to mindfulness intervention.

Asking questions:

You can ask me any questions you would like. If you think of a question later, you or your parents can reach me atxx-xxx-xxx. If you or your parents would like to ask my university a question, you can call DrXX, her phone number isxxx-xxx-xxx .
Your parent has consented to me viewing your reflective notes, but you have the choice to volunteer or say no. Please click here to tell me your decision.

Appendix D: Demographic Survey

1. Youth participant gender?
2. Youth participant age and grade level?
3. Have they meet with their school counselor at least once for depression or depressive symptoms?
4. What depressive symptoms do they experience?

- *Do you constantly feel sad, anxious, or even "empty,"?*
- *Do you feel hopeless or like everything is going wrong?*
- *Do you feel like you are worthless or helpless? Do you feel guilty about things?*
- *Do you feel irritable much of the time?*
- *Do you find yourself spending more time alone and withdrawing from friends and family?*
- *Are your grades dropping?*
- *Have you lost interest or pleasure in activities and hobbies that you use to enjoy?*
- *Have your eating or sleeping habits changed (eating or sleeping more than usual or less than usual)?*
- *Do you always feel tired? Like you have less energy than normal or no energy at all?*
- *Do you feel restless or have trouble sitting still?*
- *Do you feel like you have trouble concentrating, remembering information, or making decisions?*
- *Do you have aches or pains, headaches, cramps, or stomach problems without a clear cause?*
- *Do you ever think about dying or suicide? Have you ever tried to harm yourself?*

4. Do they currently take medication for depression or depressive symptoms?
5. Have they ever engaged in mindfulness activities
   - *Meditation*
   - *Yoga*
   - *Deep Breathing*
   - *Reflective Journaling*

5. Will attendance be an issue in completing the full 8 weeks (*1 x a week direct meeting commitment*)

Appendix E: Semi-Structure Interview Questions (Parents/Teachers)

Pre-Study Questions

1. How would you characterize (participants name) depressive symptoms currently?
2. What practices or treatments do you currently use to support (participants name) with depressive symptoms?
3. Do you have any experience with mindfulness practices, could you briefly describe your practice with mindfulness?
    a. What form/and or techniques do you use? (iP.e, breathing meditation, walking mediation, yoga)
4. How has (participants name) depressive symptoms influenced your relationship?
5. What is the biggest area of contingency that you would like (participants name) to target?

Post Study Questions

1. How would you characterize (participants name) depressive symptoms currently?
2. What behaviors have you observed from (participants name) since engaging in mindfulness interventions?
3. Where have you seen positive change in (participants name) well-being because of their practice with mindfulness?
4. What type of resistance have you experienced with (participants name) practice with mindfulness?
5. What was the biggest area of change that you observed in (participants name) over the last 8 weeks?

Appendix F: Youth Reflective Note

Name: ____
Week # _____________ Date _______________ Session Topic: ___________________________

Objective: During each weekly session you will complete the following: Emotional Checklist, Note Taking, and a Journal Prompt

Emotional Rating

Directions: Give yourself an **emotional rating** at the beginning and end of the session

1. You will choose **a journal prompt** to respond too

Emotional Rating	**Using this scale:** 1 – feeling terrible 2 – feeling bad 3 – Neutral 4 – feeling ok 5 – feelings amazing **please rate your emotional rating entering the space today.**	I am **entering** this space at a _______________ I am **leaving** this space at a _______________

Note Taking Section

Directions: Use the note taking section to capture moments during the session. You can take notes about anything that stands out to your during the delivery of the session including:

- o *Feelings, words, phrases, thoughts*

- I am feeling
- Words that stick out to me are
- Phrases that stick out to me are
- Thoughts that I am having are

Journal Prompt Section

Prompt # ___________________________

Directions: You will choose **a journal prompt** to respond too and capture your thoughts below.

Use the space below to capture additional comments about how you felt about today's session?

I enjoyed the session today: YES or NO
I did not enjoy the session today: YES or NO

JOURNAL PROMPTS

1. What are you grateful for?
2. What do you think are the biggest challenges for you so far?
3. When do you feel a relief?
4. Who can help you feel a relief?
5. What is your happiest moment of life?
6. What would be the title of your life now? Why?
7. If you could add, change, or cancel the rule at home. What would it be?
8. Who do you trust the most? Why?
9. Who are the people that you love the most? What are their characteristics?
10. What is your scariest moment (real life or fantasy moment?)
11. When do you feel the happiest?
12. What makes you feel uncomfortable?
13. What makes you happy?
14. How do you think others see you? Why?
15. What is the first symptom you notice when you feel anxious/stressed/sad?
16. How can you help yourself to relief the anxiety, stress, sadness?
17. Tell about time when you felt mad?
18. What frightens you?
19. What is something you feel nervous about right now?
20. What makes you angry?
21. What topics are you afraid to talk about? Why?
22. What can you learn from your relatives?
23. What makes you feel proud?
24. What activities do you love the most?
25. Make a list of 10 things that make you smile.
26. Make a list of 10 things that make you feel sad.
27. If you can say one word which describes your feelings now, what would it be?
28. Using only 30 words, describe yourself. Who are you?
29. What can you learn from your parents, friends?
30. Make a list of your dreams. Write it down on the paper.
31. Write a list of things that make you feel uncomfortable. Which ones can you control, how?
32. Who are your heroes?
33. What habits do you want to change? Think carefully about the plan how you can change that.
34. Write down everything that inspires you. Don ‘t forget the little things.
35. How do you imagine yourself in 5 years?
36. Make a list of everything you would like to disagree/rebel about.
37. Make a list of everything you would like to do.
38. Write the words you want to hear every day.
39. Make a list of thoughts that circulate in your mind for a while.

40. Write about a time when you did something you were afraid to try.
41. What is self-awareness?
42. Why is it important to communicate about emotions?
43. Who do you feel safe communicating your emotions/feelings with?
44. How do you feel when you get a compliment?
45. What encourages you to help another person?

Appendix G: Facilitators Reflection

Date _______________ Session Topic (optional): ___________________________

How prepared did you feel to facilitate today's session? And why?	
Was there a part of the session today that you felt went well?	
Was there a part of the session that you felt needed improvement	
What behaviors did you observe?	
What type of body language did you observe?	
How would you describe the overall session today?	
Additional thoughts or comments	

Facilitator Signature:____