

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

THE RELATIONSHIP BETWEEN DEPRESSIVE SYMPTOMS, PARENTAL
PSYCHOLOGICAL CONTROL, AND FAMILY COHESION AMONG MINORITY
ADOLESCENTS

A thesis submitted in partial fulfillment of the requirements
For the degree of Master of Science in Counseling,
Marriage and Family Therapy

by

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August 2012

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DEDICATION

This thesis is dedicated to my parents and my brother. I dedicate this to my parents, Nasrin and Hossein Fadakar, who have provided unconditional love and support in all of my endeavors. Mom, you are a true inspiration. Thank you for your compassion, understanding, and tremendous love. You are my best friend, and I'm eternally grateful for our beautiful relationship. Shahin, you are one of the most precious lights in my life, and I value our relationship.

I am blessed to have you all as my family, and I love you all very much.

ACKNOWLEDGEMENTS

There are many individuals who have been instrumental in my academic career and during my time as a graduate student. I am blessed for the opportunities that were presented to me, and I'm grateful for the people who were influential during this time.

First and foremost, I would like to thank you God. Thank you for everything you have given me in life. Through my relationship with You, I aspire to be a better person, and I strive to strengthen our relationship on a daily basis.

To Dr. Carrie Rothstein-Fisch, I learned so much from you in my first semester of graduate school and was honored to serve as your teaching assistant. Thank you for having faith in my abilities and for being a support to me.

I wanted to take this opportunity to thank my committee members. To my chair, Dr. Tovah Sands, thank you for your invaluable time and efforts in helping me with my thesis. To Dr. Scott W. Plunkett, thank you for your guidance and support through this process. I gained tremendous knowledge from working with you. Thank you Dr. Sands and Dr. Plunkett for allowing me to expand my research capabilities and to use the "Adolescent Resiliency in Multi-Cultural Communities" research study for my data. To Dr. Dana J. Stone, thank you for all your feedback and insight in helping to enrich my thesis. It was privilege to work with all of you.

The past three years have developed my growth as a person and expanded my professional development. I would like to thank my peers in my graduate program. We went from being classmates to becoming dear friends. Thank you for making our program a memorable experience. To my friends, thank you for all your support and

understanding. Through these years, I learned from each of you and I'm blessed for the friendships that I gained.

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ABSTRACT

THE RELATIONSHIP BETWEEN DEPRESSIVE SYMPTOMS, PARENTAL PSYCHOLOGICAL CONTROL, AND FAMILY COHESION AMONG MINORITY ADOLESCENTS

by

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Master of Science in Counseling,
Marriage and Family Therapy

This thesis research is part of a larger research project titled, “Adolescent Resiliency in Multi-Cultural Communities” (ARMCC). Previous research literature has focused on depressive symptoms among ethnic minority adolescents, yet little research has been conducted regarding whether parental psychological control and family cohesion relate to depressive symptoms among minority adolescents. The current research used data from 949 minority adolescents from California, North Carolina, and Oklahoma. The results of this study found a significant difference between genders on depressive symptoms, with female adolescents reporting significantly higher depressive symptoms than boys. No differences were found between genders on parental psychological control or family cohesion. Parental psychological control had a significant and positive relationship to depressive symptoms. Lastly, family cohesion had a significant and negative relationship to depressive symptoms.

CHAPTER I

INTRODUCTION

This thesis examines perceived parental psychological control and family cohesion in relation to depressive symptoms among minority adolescents. This thesis will also review depressive symptoms among minority adolescent girls and boys. This chapter provides statistical information on ethnic minorities, depression, and minority adolescents. In addition, a statement of the problem, significance of the study, and research hypotheses are addressed. Definitions of the terminology used throughout the present study are also stated.

In the United States, ethnic minorities comprise a substantial number of the nation's population. Based on the 2010 United States Census, nearly one-third of the nation's population, 111.9 million individuals, are identified as an ethnic minority. This represents close to a 29% increase from the 2000 census. Between the years 2000 to 2006, Hispanics comprised one-half of the nation's growth (Humes, Jones, & Ramirez, 2010). At the current time, there are 50.5 million individuals who identify as Hispanic, comprising 16% of the total population (Ennis, Ríos-Vargas, & Albert, 2011). It is expected by 2060, that Latinos will represent 25% of the United States population. Based on the 2010 United States Census, 38.9 million people identified as Black and an additional 3.1 million individuals reported to be of a combination of Black and another race. Since the 2000 census the Black population has grown by 12 percent, increasing by 4.2 million people. In total, nearly 14% of the United States' population identify as Black (Rastogi, Johnson, Hoeffel, & Drewery, 2011). In the United States, there are 11.9 million individuals who identified as Asian; 10.2 million identified as Asian only, while

1.7 million identified as Asian and another race (Barnes & Bennett, 2002).

In the United States, depression is considered one of the most common mental illnesses, affecting a substantial number of adults and youths. Every year, over 18 million individuals suffer from major depression, while another “7.5 million suffer from chronic low-grade depression” (Preston, O’Neal, & Talaga, 2008, p. 71). Furthermore, 50 to 60 percent of individuals experience recurring episodes and may average six episodes throughout their lifetime (Preston et al., 2008). While research on depression has primarily focused on the adult population, many professionals have sought to learn more about the prevalence and effects of depression on the youth population. Kerig and Wenar (2006) state that among adolescents, 20 to 46 percent of boys and 25 to 59 percent of girls report experiencing depressive moods.

Statement of the Problem

While depression and depressive symptoms have been studied by researchers in both the adult and youth populations, there is still a need to learn more about the environmental influences that impact depressive symptoms in minority adolescents. Depressive symptoms are universal among age, genders, ethnic, and racial backgrounds. There is a prominent stigma in society regarding the issues of mental health and receiving services. While depression is one of the more common mental illnesses, there remains a lack of understanding about depression among minority adolescents and families. More specifically, little attention has been given to how environmental factors, including parental psychological control and family cohesion, influence depressive symptoms among minority adolescents.

Research has shown that adolescents from minority groups are at a higher risk for depression (Allen & Astuto, 2009). Previous literature has shown how family dysfunction and parental control impact the prevalence of depressive symptoms in adolescents (Soenens, Luyckx, Vansteenkiste, Duriez, & Goossens, 2008). Furthermore, prior research has focused on learning more about depressive symptoms among minority adolescents (Finkelstein, Donenberg, & Martinovich, 2000; Herman, Ostrander, & Tucker, 2007). The present study focuses on perceived parental psychological control and family cohesion in relation to depressive symptoms among male and female minority adolescents.

Purpose of Study/Hypotheses

The purpose of this study was to examine the influence of parental psychological control and family cohesion on ethnic minority adolescents' depressive symptoms. Furthermore, this thesis will review gender differences in adolescents' depressive symptoms.

Based on the review of literature in Chapter 2, the following research hypotheses were developed for this thesis. Hypothesis one: Minority adolescent girls will report significantly higher depressive symptoms than minority adolescent boys. Hypothesis two: Minority adolescents' perceptions of their family cohesion will be significantly and negatively related to the adolescents' depressive symptoms. Hypothesis three: Minority adolescents' perceptions of parental psychological control will be significantly and positively related to adolescents' depressive symptoms. Hypothesis four: The relationship between family cohesion, parental psychological control, and depressive symptoms will vary based on gender of the youth.

Significance of the Study

As the nation's ethnic minority population increases, it is important to learn more about depression among ethnic adolescents and their families. There are many factors that may have an influence on depressive symptoms among children and adolescents in the United States. These factors include lower socioeconomic statuses (SES), family disruption, lack of access to educational resources, lack of medical services, unsafe neighborhoods, and poverty (Kerig & Wenar, 2006). Furthermore, there are disparities among ethnic minority groups and depressive symptoms. There have been conflicting studies among depression between African-American and European-American adolescents. However, Mexican-Americans adolescents appear prone to higher rates of depression than European-Americans (Kerig & Wenar, 2006). A study conducted by Kubik, Lytle, Birnbaum, Murray, and Perry (2003) found the prevalence for depressive symptoms among Asian-American adolescents (47%) and Hispanic-American adolescents (40%) were at higher rates than European-Americans adolescents (30%).

Between genders, research has shown an increase in depression diagnosis of adolescent females between the ages 13 to 15 (Kerig & Wenar, 2006). By the age of 16, female adolescents are twice more likely to be diagnosed with depression than males (Hankin et al., 1998). Additionally, female adolescents are more likely to experience depressive symptoms than adolescent boys. Girls display internalizing characteristics, such as anxiousness, vulnerability, somatization, and worry, while boys are more likely to exude externalizing qualities. Externalizing qualities include aggression, anti-social behavior, deceitfulness, and mistrust of others (Kerig & Wenar, 2006).

The present study will contribute to the literature by exploring depressive symptoms among ethnic minority adolescents. Parental psychological control and family cohesion will be examined as potential contributors to adolescents' depressive symptoms. This thesis will provide insight to society on one of the most common mental illnesses affecting adolescents of all races, ethnicities, ages, and genders, that is, depression. Therefore, the results of this study will increase knowledge and awareness on the issue of depression among ethnic minority adolescents and encourage practitioners to take precautionary measures in order to help those individuals.

Definitions

The following are terms that are used throughout this thesis project. Definitions were gathered through the review of literature. Some definitions were direct citations from the literature, while others were based on the researcher's knowledge.

Adolescence refers to the stage of development when youth experience pubertal development and explore self-identities (Steinberg, 2005). In this thesis, adolescents' ages ranged from 12 to 18 years old.

Asian-American "refers to people having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent" (Barnes & Bennett, 2002, p. 1).

Black/African-American refers to "any person having origins in any of the Black racial groups of Africa" (Humes et al., 2011, p. 3). The terms Black and African-American will be used interchangeably throughout this study.

Depression refers to a mental disorder where feelings of sadness, hopelessness, and lack of pleasure are experienced (American Psychiatric Association [APA], 2000).

Depressive symptoms refer to "feelings of sadness and disappointment are part

of the human condition. Symptoms that are intense, pervasive, and persistent and that interfere with a person's ordinary functioning are considered pathological" (Grinspoon, 1983, p. 411).

Ethnicity refers to "a group's commonality of ancestry and history, through which people have evolved shared values and customs over the centuries. Based on a combination of race, religion, and cultural history" (McGoldrick, Giordano, & Garcia-Preto, 2005, p. 2).

Family cohesion refers to the "emotional connectedness between family members and is known to be important for children's development and functioning" (Franko et al., 2008, p. 360).

European/White/Caucasian refers to "any person having origins in any of the original peoples of Europe, the Middle East, or North Africa. It includes people who indicate their race as 'White,' such as Irish, German, Italian, Lebanese, Arab, Moroccan, or Caucasian" (Humes et al., 2011, p. 3). The terms European, White, and Caucasian will be used interchangeably throughout this study.

Hispanic/Latino/a refers to "any person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race" (Humes et al., 2011, p. 2)

Minority adolescent in this thesis refers to individuals who self-reported as being Hispanic/Latino/a, Black/African-American, Asian-American, Native Americans, Caucasian/White with immigrant parents, and mixed race.

Parental psychological control refers to a "characteristic of parents who pressure their children to behave and think in accordance with parental goals and norms through

internally controlling and manipulative means (Soenens et al., 2008, p. 412).

Bridge to Literature Review

In Chapter two the literature review will provide detailed information about ethnic minority families. This section will address minority family's perceptions on receiving mental health services on both national and global levels. The next section will focus on the characteristics of depressive symptoms among adolescents. The literature will further examine the prevalence rates of depressive symptoms among minority adolescents, including European/Caucasian/White, Hispanic/Latino/a, African-American, and Asian Americans. The last section will review the effects of family cohesion and parental psychological on minority adolescent depressive symptoms.

CHAPTER II

REVIEW OF LITERATURE

This literature review provides an overview of adolescent development and ethnic minority families in the United States and their perceptions of mental health issues. The review of literature also provides an overview of depressive symptoms among minority adolescents and how parental psychological control and family cohesion impact depressive symptoms of minority adolescents.

Adolescence

Adolescents comprise 14% of the United States' population, and it is expected by the year 2020 that nearly 45% of adolescents will identify as an ethnic minority (Cobb, 2010). In many cultures, adolescence can begin as early as age 11 (Steinberg, 2005). The period of adolescence can end between 18 years old to early twenties. Adolescence is marked by a time when youth experience pubertal growth and explore their self-identities (Steinberg, 2005). During pubertal development, adolescents experience physical changes to their appearance and the onset of sexual interests. It is during this time that adolescents develop primary and secondary sex characteristics. These characteristics include body growth, growth of pubic hair, facial and underarm hair, breast development, growth of testes, and change in voice.

During adolescence, individuals' exploration towards their self-identity is further evaluated (Steinberg, 2005). Adolescents are challenged with various characteristics that help shape their identity development. Characteristics may include an adolescent's ethnicity/race, sexual orientation, social status, ethics, and morality (Consolacion,

Russell, & Sue, 2004; Steinberg, 2005). The next section will examine how various ethnic and racial groups raise their youth.

Adolescent development perceptions and parent-child dynamics are varied among ethnic minority groups. Within the African American culture, youth are often raised to be assertive, yet taught to be compliant to the needs of the family (Blair, Blair, & Madamba, 1999). They are expected to help with parental responsibilities to further gain a sense of autonomy and competence (McGoldrick et al., 2005). African Americans generally place high emphasis on strict discipline and religion to help their offspring prepare for discrimination and prejudice (Blair et al., 1999).

The Hispanic/Latino cultural group typically raises their offspring to adhere to the value of family (Locke, 1992). In Hispanic/Latino families, fathers are generally the authority figure, and youth are expected to obey parental responsibilities and demands (Blair et al., 1999). Religion, specifically Catholicism, plays a prominent role in many Hispanic/Latino families. Adolescents are expected to comply with traditional gender roles, giving boys more freedom and autonomy than girls. The Hispanic/Latino cultural groups' perception on traditional gender roles, strong family values, and focus on religion influence the way adolescents are raised.

Similar to Hispanic/Latino families, Asian Americans generally emphasize a strong family unit (Blair et al., 1999). While Asian Americans stress a patriarchal family system, mothers often enforce the parental responsibilities. The mother's role is to provide nurturance and support, while the father's role is to be a disciplinarian (McGoldrick et al., 2005). In Asian cultures, the adolescent's "sense of identity comes from the family group identity and one's position in the family" (Lee, 1997, p. 176).

Ethnic minority adolescents are consistently exposed to various life stressors that White/Caucasian adolescents may not find as detrimental (Prelow & Guarnaccia, 1997). For example, Hispanic adolescents reported experiences involving discrimination as a stressor in their life (Cervantes, Padilla, & de Synder, 1991). African American adolescents expressed not being able to relate to teachers and other school personnel as stressful events (Mosley & Lex, 1990). Ethnic minority youth, along with their parents, are faced with economic hardships that impact the adolescent's "psychological and physical well-being" (Taylor, Seaton, & Rodriguez, 2002, p. 280). Ethnic minority families and adolescents can find themselves with lack of access to housing and health care, as well as lack of access to food (Taylor et al., 2002). For parents, the economic downfalls and stressors can modify their response level to the needs of the children (Taylor et al., 2002). The next section will provide further details regarding ethnic identity development and how it relates to minorities.

Ethnic Identity Development

Ethnicity can be defined as "a group's commonality of ancestry and history, through which people have evolved shared values and customs over the centuries" (McGoldrick et al., 2005, p. 2). Ethnic identity is defined by the "total of group members' feeling about those values, symbols, and common histories that identify them as a distinct group" (Smith, 1991, p. 182). There have been multiple theories focused on ethnic identity development (Cross, 1971, 1980; Helms, 1989). Within each ethnicity and race, there are distinctions that separate membership between an overall ethnicity and race. For example, according to the United States Census Bureau, White refers to "a person having origins in any of the original peoples of Europe, the Middle East, or North Africa"

(Humes et al., 2011, p. 3). While these races and ethnicities comprise the overall “White” race, there are significant differences between each of them. Smith (1991) explains that these differences may be attributed to “family structure, the types of family roles men and women assume, the belief systems one subscribes to, the value orientations that one is raised with, the language, ethnic signs and symbols, and reference group perspective one shares with others” (p. 181). Smith uses ethnic identity development to evaluate the majority/minority status that individuals are categorized in. Majority status is defined by “a group’s superior, numerical representation within a given society; however, it may also be defined on the basis of a group’s position of power within a society” (Smith, 1991, p. 182).

During the period of adolescence, minority adolescents begin to explore their ethnic identities and minority status (Phinney & Chavira, 1995). Research has shown that ethnic identity is positively associated with self-esteem (Phinney, Cantu, & Kurtz, 1997) and academic achievement (Fuligni, Witkow, & Garcia, 2005) among ethnic minority adolescents. In high school, minority adolescents may face racism and prejudice as they involve themselves in new opportunities. As adolescents are subjected to discrimination and stereotypes, the perceptions about their ethnic identity and how they handle discrimination is a significant predictor to their socialization process. Ethnic minority parents strive to prepare their children to cope with the discrimination and racism that are directed at them (Phinney & Chavira, 1995).

Minority Families and Depression

Ethnic minority families comprise a substantial number of the United States’ population (Humes et al., 2011). Based on the United States 2010 Census, the Hispanic

and Black populations constitute 30% of the total population. Among minority families, the issues of mental health may have a significant impact on families and children. Mental health issues are prevalent among ethnic minorities on both national and global levels (Knifton et al., 2010).

Research has shown that depression goes unrecognized and is not treated as much among ethnic minority groups (Chung et al., 2003). There are barriers that prevent ethnic minorities from gaining the proper services that could be beneficial to their psychological, emotional, and physical being (Knifton et al., 2010). These barriers include language and communication discrepancies, lack of awareness about resources available, and shortage of access to bilingual health professionals (Klimidis, Minas, & Kokanovic, 2006). Also, in certain cultures, having a mental health problem is considered unacceptable (Knifton et al., 2010). For example, among South Asian communities, families are concerned about the discrimination, criticism, and shame that may be brought on if a family member has a mental health problem (Knifton et al., 2010).

In the United States, Hispanic/Latinos comprise one of the largest ethnic minority groups. Among Latino Americans, *familism* is the “cultural value and belief that the family is central in the life of the individual” (Bermudez, Kirkpatrick, Hecker & Torres-Robles, 2010, p.157). A study by Bermudez et al. (2010) explored the attitudes and behaviors regarding seeking mental health services among Latinos. Over 700 questionnaires were mailed to individuals with the Hernandez and Garcia surnames, and 94 individuals responded to the self-report survey. Participants included individuals who were born in the United States and individuals who were from Mexican origin, Cuba, Colombia, Puerto Rico, and Venezuela. Researchers focused on questions addressing

familism, personalism, sense of hierarchy, spiritualism, and fatalism. *Personalism* is how Latinos define “their self worth by their inner qualities that give them self-respect, an inner sense of dignity, and the ability to earn the respect of others” (Bermudez et al., 2010, p.157). *Sense of hierarchy* refers to the social class that Latinos belong to (Bermudez et al., 2010). *Spiritualism* is the “value that emphasizes achieving spiritual goals even if it is at the cost of sacrificing material satisfaction” (Bermudez et al., 2010, p. 158). Cultural *fatalism* refers to one’s “strong sense of destiny and a belief in divine providence governing the world” (Bermudez et al., 2010, p. 159). The results of the study revealed that participants agreed with most statements regarding *familism* and *personalism*. However, participants had mixed feelings toward sense of *hierarchy*, *spiritualism*, and *fatalism*. When it came to seeking help and psychotherapy for mental health problems, Latinos were more likely to seek guidance from a family member rather than a mental health professional. Furthermore, Latinos were also more likely to receive services from psychiatrists, psychologists, and clergy than from a marriage and family therapist.

To demonstrate the attitudes of ethnic minorities regarding mental health issues on a global level, Knifton et al. (2010) examined the attitudes of Black and other ethnic minorities in Scotland. This research consisted of 257 participants, who had migrated from India, Pakistan, and China. Participants were involved in 26 mental health awareness workshops. Researchers aimed to learn more about the impact and value the workshops had on the participants and to see if their perceptions of mental health services changed. The workshops lasted over a 9-week period, and each consisted on average of nine participants. The results indicated that in solidarity, participants agreed that mental

health problems are “common, people are not to blame, can happen to anyone, and people recover” (Knifton et al., 2010, p. 500). Overall, nearly 80% of participants stated they learned something from the workshops, with only 14% stating they did not learn anything. When asked if their beliefs had changed, nearly 78% of participants reported to have changed their beliefs regarding mental health services. This research study explains the attitudes of individuals regarding depression and the stigma associated with it. Knifton et al. show that with awareness and knowledge, society’s perceptions on depression can be altered.

Depression

Depression affects a substantial number of individuals in both the United States and in the rest of the world. Research has shown that while depression affects all racial groups, ethnic minorities are prone to higher levels of despair due to lack of quality resources and care (Fortuna, Alegria, & Gao, 2010). Furthermore, ethnic minorities are least likely to receive help in dealing with depression (Harman, Edlund, & Fortney, 2004; Van Voorhees, Walters, Prochaska, & Quinn, 2007). A study by Alegría et al. (2008) demonstrated that of 8,762 participants, 62.7% of Latinos, 68.7% of Asians, and 58.8% of African-Americans compared to 40.2% of Caucasians did not receive treatment for their depression. The next section will discuss the characteristics of major depressive episode and dysthymic disorder.

Characteristics of Major Depressive Episode

According to the Diagnostic and Statistical Manual of Mental Disorder TR-IV (DSM-IV-TR), major depressive episode can be defined as “a period of at least 2 weeks during which there is either depressed mood or loss of interest or pleasure in nearly all

activities” (American Psychiatric Association [APA], 2000, p. 349). There are nine criteria that comprise the major depressive episode diagnosis. To receive a diagnosis of major depressive episode, at least five of the nine symptoms must be present during the 2-week span and must be visible for most of the day, almost every day (APA, 2000).

Criterion A1 states an individual feels “depressed, sad, hopeless, discouraged, or ‘down in the dumps’ (APA, 2000, p. 349). Criterion A2 notes a “loss of interest or pleasure is nearly always present, at least to some degree” (p. 349) and Criterion A3 recognizes a reduction in appetite and “significant loss or gain in weight” (APA, 2000, p. 349-350). A symptom that is attributed to major depressive episode is disruption to sleep. Criterion A4 acknowledges insomnia and hypersomnia as prevalent symptoms. Criterion A5 focuses on “psychomotor changes including agitation, such as inability to sit still, pacing, handwringing, or retardation, which consists of slowed speech, thinking, and body movements” (APA, 2000, p. 350). Other symptoms include “decreased energy, tiredness, and fatigue” (Criterion A6, p. 350) and a “sense of worthlessness or guilt” (Criterion A7) (APA, 2000, p. 350). Criterion A8 states an individual displays diminished “ability to think, concentrate, or make decisions” (APA, 2000, p. 350). Lastly, individuals may experience “thoughts of death, suicidal ideation, or suicide attempts” (Criterion A9) (APA, 2000, p. 350). These symptoms for major depressive episode increase gradually over the course of days to weeks.

According to the APA (2000), the symptoms of depression listed for adults remain the same for children and adolescents. However, the age of the child or adolescent impacts the depressive symptoms. Children and adolescents may exhibit moods that are

more irritable than sad. With regard to weight, children may not reach appropriate weight for their age group (APA, 2000).

Characteristics of Dysthymic Disorder

Dysthymic disorder can be classified as “a chronically depressed mood that occurs for most of the day more days than not for at least two years” (Criterion A) (APA, 2000, p. 376). A significant distinction between symptoms of adults and youth is that with children and adolescents, the persisted depressed mood lasts for at least one year not two years as with adults. Individuals must display two or more of the following symptoms while depressed: “poor appetite or overeating, insomnia or hypersomnia, low energy and fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness” (Criterion B) (APA, 2000, p. 380). As with major depressive episode, the negative mood can be presented as more irritable than sad among children and adolescents. Furthermore, in the two-year span (one year for children and adolescents), an individual can be free of symptoms no longer than two months (Criterion C) (APA, 2000). Criterion D states that a diagnosis of dysthymic disorder is only given if there are no symptoms of major depressive episode presented during the first two years (APA, 2000). Also, a diagnosis of dysthymic disorder cannot be given if there has ever been a “Manic Episode, a Mixed Episode, or a Hypomanic Episode” (APA, 2000, p. 380).

Dysthymic disorder can be specified by early onset, in which “symptoms occur before the age of 21, and Late Onset, when symptoms occur at the age of 21 or older” (APA, 2000, p. 377). The other classifications for a diagnosis of dysthymic disorder include “significant impairment in social, occupational, or other areas of functioning,

symptoms are not due to the direct physiological effects or a general medical condition, and disturbance does not occur exclusively during the course of a chronic Psychotic Disorder” (APA, 2000, p. 380).

The APA (2000) states that, “children and adolescents with Dysthymic Disorder are usually irritable and cranky as well as depressed” (p. 378). Additionally, children and adolescents have “low self-esteem, poor social skills, and are pessimistic” (APA, 2000, p. 378). Approximately, 6% of the adult population suffers from dysthymic disorder (APA, 2000), however, the prevalence is unknown among the child and adolescent populations.

Depressive Symptoms Among Minority Adolescents

Although research has been conducted on depression among ethnic and racial minority groups, more information is needed regarding depressive symptoms among ethnic minority adolescent boys and girls. Adolescents from ethnic and racial minority groups are at a higher risk for depression than European American adolescents (Doi, Roberts, Takeuchi, & Suzuki, 2001; Kubik et al., 2003). There are several unique factors that influence depression rates among minority adolescents. These factors include socioeconomic status (SES), social support, family cohesion, and peer support (Allen & Astuto, 2009).

In early to middle adolescence, primarily 12-14 year olds, Roberts and Chen (1995) found that among 2,614 middle school students, adolescents from Mexican descent were more likely to report depressive symptoms compared to non-Latino Whites. Among 12-13 year old adolescents, research showed that of a sample of 3,621 participants, American-Indian adolescents reported higher levels of depressive symptoms

and non-Latino Whites reported the lowest rates of depression in comparison to other ethnic groups (Kubik et al., 2003).

Other research on depressive symptoms among adolescents has shown that European Americans/Whites are at a higher risk than ethnic and racial minority adolescents. For example, a study by Brooks, Harris, Thrall, and Woods (2002) examined the prevalence of depression among 2,224 adolescents from 32 schools in the state of Massachusetts. The sample consisted of Black, White, and Latino students from all high school grade levels. Participants were asked, "In the last 30 days, how many days did you feel depressed/stressed?" The results showed that Blacks and Latinos had significantly less feelings of being depressed than White adolescents. Furthermore, a study of 10,041 adolescents from high schools in the San Francisco Bay area and Wisconsin found that Asian Americans, Blacks, and Latinos reported less depressive symptoms than White adolescents (Dornbusch, Mont-Reynaud, Ritter, Chen, & Steinberg, 1991).

While research has focused on mutually exclusive ethnic and racial groups, one particular research aimed to study adolescents who identify with more than one ethnic and racial group. A study conducted by Ramos, Jaccard, and Guilamo-Ramos (2003) examined the rate of depressive symptoms among European American, African American, Latino, and Afro-Latino adolescents. Afro-Latinos typically uphold the customs and culture of Latinos, however they exhibit the physical characteristics that are affiliated with African ancestry (Ramos et al., 2003). This study consisted of 20,745 adolescents in Grades 7 through 12, and data collection took place between September 1994 and April 1995. Additionally, the sample included 1,038 Black adolescents with at least one parent with a college degree, 334 Chinese adolescents, 450 Cuban adolescents,

and 437 Puerto Rican adolescents. Researchers were interested in how adolescents perceived negative affect, positive affect, interpersonal relations, and somatic symptoms. Researchers proposed two opposing hypotheses. The first hypothesis stated that Afro-Latinos would exhibit lower levels of depressive symptoms than both African Americans and Latinos due to social and cultural traditions. On the other hand, the second hypothesis stated Afro-Latinos would display higher levels of depressive symptoms than African Americans and Latinos due to being part of two cultural social groups, which can elicit “ethnoracial loyalties, feelings of ambivalence, and additional burdens” of each cultural group (Ramos et al., 2003, p. 165). The results of this study found that Afro-Latino female adolescents exhibited higher levels of depressive symptoms related to negative affect, positive affect, interpersonal relations, and somatic symptoms than other ethnic groups. Afro-Latino boys reported higher levels on the negative affect component than other ethnic groups. This study found that minority adolescent girls reported higher levels of depressive symptoms than boys, and adolescents in high school (grades 9 through 12) are more likely to report depressive symptoms than younger adolescents.

Gender Differences in Depression among Minority Adolescents

From childhood to adulthood, women are twice as likely to experience depression as men (Nolen-Hoeksema, 1991; 2001). Research has shown that in the course of one’s lifetime, major depressive disorder is prevalent among 21.3% of women compared to 12.7% of men (Kessler, McGonagle, Swartz, Blazer, & Nelson, 1993). Nolen-Hoeksema (2001) found by the age of 13, depression among adolescent girls increases while depression among adolescent boys remains low or even decreases.

Research conducted by Rohde, Beevers, Stice, and O'Neil (2009) examined major depressive disorder and minor depression among female adolescents. This seven year longitudinal study consisted of 496 female adolescents between 12 to 15 years old ($M = 13.1$). The results of this study found that one out of six female adolescents experienced major depressive disorder lasting 5.3 months on average. With regard to minor depression rates, the results showed minor depression was highest at the age of 14 and lowest at the age of 20 for adolescent females.

Ethnic and Racial Groups and Adolescent Depressive Symptoms

A study by Céspedes and Huey (2008) reviewed the impact of Latino culture and family dynamics on the prevalence of depressive symptoms among 9-12 grade, Latino adolescents ($n = 130$, 70% girls) in Los Angeles. Over 33% stated Spanish was their primary language. From the sample, 48% of participants identified as Central American, primarily Salvadoran and Guatemalan, 43% identified as Mexican American, 7% identified as both Central and Mexican American, and 2% identified as Other Latino. Céspedes and Huey (2008) focused on family dysfunction and the acculturation process between Latino adolescents and their immigrant parents. It was hypothesized that cultural discrepancies would have an effect on depressive symptoms among Latino adolescents. Furthermore, researchers hypothesized discrepancies between parent and child would have a more significant impact on female than on male adolescents. The measurements used for the Céspedes and Huey (2008) included the Acculturation Rating Scale for Mexican Americans II (ARSMA-II; Cuéllar, Arnold, & Maldonado, 1995) to assess for acculturation levels. To assess family functioning, the Family Environment Scale (FES; Moos & Moos, 1981) was used, specifically the conflict subscale. To measure

depression, the Reynolds Adolescent Depression Scale-2 (RADS-2; Reynolds, 2002) was used. Other measurements included scales focused on gender role beliefs and cultural discrepancy. Céspedes and Huey found that adolescents' perceptions of cultural discrepancy between the adolescent and parent were not associated with depression or family dysfunction. They also found that Latina adolescents reported higher levels of depression compared to Latino male adolescents. The prevalence of depression was shown at greater levels when gender role beliefs and family dysfunction were factored. The discrepancies for gender role beliefs had a profound effect on Latina adolescents, but not on male adolescents. The importance of this study showed that cultural discrepancy between parent and child does have a significant effect on adolescent depression.

A study conducted by Moon and Rao (2010) examined the relationships between family dynamics, school environment, and adolescent depression among ethnic and racial groups (White, Black, Asian, and Hispanic). The researchers further made comparisons between the depressive symptoms of adolescents and the ethnic and racial groups, as well as the distinctions between the adolescent-family relationships and adolescent-school relationships. Moon and Rao obtained data from the National Longitudinal Study of Adolescent Health and the sample consisted of 2,287 boys (47.8%) and 2,496 girls (52.2%). The age of participants ranged from 11 to 21 years old ($M = 16.01$). To measure depressive symptoms, the Center for Epidemiologic Studies-Depression Scale (CES-D; Radloff, 1977) was administered. The family relationship variable was measured by a four-item scale, and child-school relationship was measured by a six-item scale (Moon & Rao, 2010). Moon and Rao found that adolescents who reported good relationships with family and school were less likely to have depressive symptoms. While this research

concluded with previous literature that positive relationships in the lives of adolescents promotes psychological health, it further enhanced the understanding of depressive symptoms among ethnic and racial groups. Researchers found among ethnic and racial groups, Hispanics and Asians were more likely to exude depressive symptoms than Black and White groups (Moon & Rao, 2010). Adolescents reported feeling “caught between two cultures” and finding themselves in between remaining loyal to traditional values while adapting to the mainstream culture (Moon & Rao, 2010). Coincidentally, the results showed adolescent-family relationships were stronger for Asians and Hispanics than Whites and Blacks. On the other hand, adolescent-school relationships were more predominant among White and Black groups than Asian and Hispanic groups. In conclusion, Moon and Rai’s study provided sufficient motivation to further explore the depressive symptoms of adolescents among ethnic and racial groups.

A study conducted by Needham (2008) examined the relationship between parental support and depressive symptoms from adolescence to adulthood, as well as examining gender differences during this transition. Needham hypothesized that perceived parental support would impact depressive symptomatology through young adulthood and parental support would have a “stronger impact on symptoms of depression among girls than boys” (p. 896). Furthermore, adolescents who self-reported higher levels of depressive symptoms and continued growth of symptoms in young adulthood would have lower levels parental support. Lastly, the level and changes of depressive symptoms among young men would have a stronger association with parental support than young women. The data collection for the Needham study took place over the course of three time periods. The first wave of data collection consisted of 20,745

participants with an average age of 15.28. The second phase was a year later and consisted of 11,621 participants. The last data collection took place five years later and consisted of 10,828 participants ($M = 21.65$). This study consisted of diverse ethnic and racial groups, which included Whites, Blacks, Latinos, and individuals who identified as “other”. However, the specific number of each ethnic and racial group was not provided. Needham interviewed participants in all three waves and asked questions from the CES-D Scale. The researcher assessed maternal and paternal support, as well as overall parental support. Lastly, the researcher controlled for gender, ethnicity/race, parental level of education, and family structure. The results of the Needham study found that adolescents who self-reported higher levels of depressive symptoms at the start of the study were less likely to have parental support in their young adulthood. Even participants, who regardless of what they reported in the initial intake about their depressive symptoms, were shown to have lower levels of parental support in young adulthood (Needham, 2008). In the first wave of this study, adolescents who reported higher levels of depressive symptoms reported lower levels of parental support by the end of the study. Adolescent girls were more likely to report higher levels of depressive symptoms and lower levels of parental support than adolescent males. In conclusion, this study showed how influential parental roles are in the lives of adolescents. Adolescents who experience less parental support are more likely to experience depressive symptomatology. Furthermore, lack of parental support transcends into young adulthood.

A study by Chung, Chen, Greenberger, and Heckhausen (2009) sought to examine adolescent depression while investigating parental and peer warmth. The researchers aimed to study the transition from adolescence to young adulthood. Researchers

hypothesized symptoms of depression present during high school would be negatively correlated with parental and peer warmth one year later. Researchers further explored ethnic and racial groups. They hypothesized that parental and peer warmth amongst individualistic cultures, such as European-Americans, would be less obvious than family-oriented, collectivistic cultures, such as Asian and Hispanic-Americans. The Chung et al. study was comprised of two phases. The first phase consisted of 1,183 (M age = 17.8) participants from four high schools in the Los Angeles Unified School District. There were 154 participants who identified as European-American, 205 Hispanic-Americans, and 152 Asian Americans. The second phase consisted of 754 participants, and data were collected one year after graduation and phase one. The measurements used in the Chung et al. study included the eight-item Parental Warmth and Acceptance Scale (Greenberger & Chen, 1996). To assess peer warmth, researchers modified the statements on the Parental Warmth and Acceptance Scale and directed it to focus on peers. Depressive symptoms were measured using the 20-item CES-D Scale (Radloff, 1997). The results for the Chung et al. (2009) study demonstrated that among European-Americans, initial symptoms of depression were negatively correlated with perceived parental and peer warmth. With regard to cultural groups, the association between parental and peer warmth and symptoms of depression were not evident among Hispanic-Americans. Hispanic-American parents were shown to provide their adolescents continued support and warmth regardless of depressive symptoms. Among Asian Americans “depressed mood was significantly negatively associated with changes in peer warmth, but that association was only marginal for parental warmth” (Chung et al., 2009, p. 373). On an interesting note, this study included a high number of Filipino participants, who have

similar individualistic traits as European-Americans. In conclusion, researchers identified possible confounding variables that could influence the results of this study such as gender that could have had effects on the outcomes.

To further understand the prevalence of depression among Asian Americans, Wong (2000) studied 144 high school adolescents from the San Francisco Bay area. Participant's ages ranged from 14 to 19 years old ($M=15.7$). The sample consisted of 71 boys and 73 girls. Also, 79 of the participants were born in the United States, while 65 were born in another country. Wong proposed four hypotheses for the study. The first hypothesis stated that Asian American adolescents would experience higher levels of depression compared to White adolescents. The second hypothesis proposed that bicultural adolescents would report lower levels of depressive symptoms. The third hypothesis stated that parental and peer relationships would be negatively correlated to depression. The last hypothesis that depression would differ when the following variables are reviewed: gender, migration status, SES, and ethnic group membership. The results found that Asian American adolescents reported having greater levels of depression compared to White adolescents. With regard to the second hypothesis, there were no significant differences on depressive symptoms among the cultural groups. For the third hypothesis, the results showed that parental and peer relationships were negatively correlated with depressive symptoms. The last hypothesis addressed certain variables, such as gender, migration status, and SES. The results showed that there were no significant differences among depression between female and male adolescents. Further results showed that adolescents who migrated later in life reported higher levels of depression. There were no significant differences between adolescents who were born in

the United States and adolescents who immigrated earlier in their life. Lastly, SES was found not to be statistically significant on depressive symptoms among Asian American adolescents.

Overall, researchers have sought to learn more about depressive symptoms among adolescents from multiple ethnic and racial groups. The studies reviewed show conflicting results regarding White, African American, Hispanic, and Asian American adolescents. The most important factor obtained through this section demonstrates that depressive symptoms affects adolescents of all ethnic and racial groups. While depressive symptoms among ethnic and racial adolescents have been reviewed, the next section will explore how family cohesion and parental psychological control influence depressive symptoms among the different ethnic groups.

Parental Psychological Control, Family Cohesion, and Depressive Symptoms

Research has shown the importance of parental relationships in the life of adolescents (Owens, Scofield, & Taylor, 2003; Wilkinson, 2004). Positive parental relationships are highly correlated with adolescent self-esteem (Parker & Benson, 2004). Research has shown that positive parent-child relationships are associated with fewer symptoms of depression, anxiety, and a greater self worth (Ackard, Neumark-Sztainer, Story, & Perry, 2006). Additionally, supportive parental relationships and warmth reduce depressive symptoms among adolescents (Galambos, Barker, & Krahn, 2006).

Previous literature has shown the strong correlation between parental psychological control and depressive symptoms among adolescents (Soenens et al., 2008). Parental psychological control can be defined as the “characteristic of parents who pressure their children to behave and think in accordance with parental goals and norms

through internally controlling and manipulative means” (Soenens et al., 2008, p. 412). Psychological control from parents can come in the form of “guilt induction, shaming, and conditional approval” (Barber, 1996, as cited in Soenens, Vansteenkiste, Luyten, Duriez, & Goossens, 2005, p. 412).

An extensive longitudinal study sought to learn the effects of parental psychological control among college-aged and high school adolescents (Soenens et al., 2008). The research study was divided into Study 1 and Study 2. The researchers controlled for psychological control effects model, adolescent adjustment effects model, and a reciprocal model. Psychological control effects model allows researchers to make assumptions regarding the direction of effects. The adolescent adjustment effects model suggests that, “children’s behavior elicits particular parental reactions (Soenens et al., 2008, p. 414). The reciprocal model predicts that “parents of less adjusted adolescents would be more likely to reply on psychologically controlling strategies that, in turn, would further increase children’s susceptibility to depression (Soenens et al., 2008, p. 415). By utilizing the three models in this study, researchers can make direct associations between them. In Study 1, the sample consisted of 565 college students with an average age of 18 years old and 8 months. Over 85% of the participants were female students ($n = 482$). Participants completed a 21-item questionnaire from the Children’s Report on Parent Behavior Inventory (CRPBI) (Schaefer, 1965; Soenens et al., 2005) and a 12-item questionnaire assessing depressive symptoms. The results for Study 1 found that parental psychological control and adolescents’ depressive symptoms were highly correlated to one another. Depressive symptoms among college students increased during the first three years of school. Study 2 focused on high school aged adolescents in Belgium and

consisted of 441 females and 463 males. Since the results from Study 1 could not be generalized due to the predominant female sample, researchers aimed to generalize Study 2 to other adolescents. Participants completed a 6-item questionnaire assessing psychological control and the same 12-item depressive symptoms questionnaire in Study 1. The results from Study 2 showed adolescent depressive symptoms increase over time in relation to parental psychological control.

Family cohesion can be defined as the “emotional connectedness between family members and is known to be important for children’s development and functioning” (Franko et al., 2008, p. 360). A study by Herman et al. (2007) sought to investigate how family environment influences depressive symptoms among ethnic adolescents. The sample for this study consisted primarily of European American and African American adolescents. Researchers specifically aimed their focus on family cohesion, family conflict, adolescent cognitions, and depressive symptoms among both ethnic communities. The Herman et al. study consisted of 51 European American adolescents (28 girls and 23 boys) and 32 African American adolescents (23 girls and 9 boys). The mean age for the African American adolescents was 13.3 and for European American it was 13.8. The measurements used in this study included the Centers for Epidemiological Studies-Depression (Radloff, 1977) and the Family Relations Index (FRI; Moos & Moos, 1986). Other instruments were used to measure adolescent self-discrepancy and social desirability. Herman et al. utilized multiple regression analyses to determine the predictive factors of adolescent depression. Among African American adolescents, the results showed that lower levels of family cohesion were associated with depressive symptoms. Interestingly, researchers stated that, “reducing family conflict for African

American families with a depressed child may not be sufficient to alleviate depression” (Herman et al., 2007, p. 329). Instead, researchers proposed building stronger family connections as a way to reduce depressive symptoms. The researchers reported that higher levels of family conflict were statistically significant and related to depressive symptoms in European American adolescents. Researchers stated that family conflict inflicts additional life stressors in the adolescent’s life and amplifies the depressive symptoms.

A study by Finkelstein et al. (2000) focused on maternal psychological control and adolescent depressive symptoms among Caucasian, African-American, and Hispanic/Latina females. The sample consisted of 111 participants: 41 Caucasian, 50 African-American, and 20 Hispanic/Latinas from the Midwest. The participants’ ages ranged from 12 to 18 years old ($M = 15.65$). Researchers hypothesized that higher levels of maternal control would be associated with higher levels of depression among Caucasian females but higher levels of maternal control would show lower levels of depressive symptoms among African American females. Participants were asked to complete the Anxious-Depressed subscale of the Youth Self-Report (YSR; Achenbach, 1991) and the CRPBI to measure adolescents’ perceptions of parental control. The results found no significant relationship between maternal control and adolescents’ depressive symptoms. However, once ethnicity was factored in, the results found that African American and Latina adolescents reported higher levels of maternal control than Caucasian females. Higher levels of maternal control were linked lower levels of depressive symptoms in African American female adolescents. The results of this study confirmed that ethnicity is an important factor in the relationship between maternal

control and female adolescents' depression. According to Finkelstein et al. future research should assess how paternal control impacts depressive symptoms among female adolescents. Furthermore, assessing both maternal and paternal control and depressive symptoms among male adolescents would be useful for understanding male perceptions.

Healthy family dynamics and cohesion can play an influential role in the psychological health of an adolescent. A study by Sheeber, David, Leve, Hops, and Tildesley (2007) found having a good relationship with parents and siblings will reduce the likelihood of an adolescent becoming "depressed, developing problems, or considering suicide" (as cited in Moon & Rao, 2010, p. 116). Furthermore, research has shown that parents who display warm and caring feelings tend to have children who display lower levels of depressive symptoms (Greenberger & Chen, 1996).

A study conducted Dmitrieva, Chen, Greenberger, and Gil-Rivas (2004) examined the relationship between parent-adolescent conflict, negative family events, and adolescents' depressive symptoms. This study contained 1,696 11th grade adolescents from the United States ($n = 201$), China ($n = 501$), Korea ($n = 497$), and the Czech Republic ($n = 496$). The average ages for the participants in each country were 16.65 in the United States, 17.64 in China, 16.47 in Korea, and 16.86 in the Czech Republic. These countries were selected due to their individualistic and collectivistic cultures and their social and economic development. All countries had approximately 50% boys and girls. Researchers hypothesized perceived parental involvement and parent-adolescent conflict were highly related to depressed mood in collectivistic cultures including China and Korea (Dmitrieva et al., 2004). However, perceived parental sanctions and problem behaviors among adolescents from China and Korea were expected to have a low

association. Lastly, researchers reviewed gender differences and expected female adolescents to report higher levels of depressed mood. With regard to problem behaviors, female adolescents were expected to report lower levels of involvement. To assess for perceived parental warmth, researchers (Dmitrieva et al., 2004) used 11 items from the Perceived Parental Warmth scale (Greenberger & Chen, 1996). To measure parental involvement, the 10-item Parental Knowledge scale was used (Chen, Greenberger, Lester, Dong, & Guo, 1998). Further scales were used to measure parent-adolescent conflict, perceived parental sanctions, family-related negative life events, depressed mood, and adolescent problem behaviors were all assessed. The results of this study found that family-related negative life events were associated to lower levels of parental involvement and higher levels of parent-adolescent conflict (Dmitrieva et al., 2004). Furthermore, the lack of quality in the parent-adolescent relationship also showed higher levels of depressed mood. With regard to ethnic cultures, perceived parental sanctions among Chinese and Korean adolescents were not highly associated to problem behaviors. On the other hand, parental involvement and parent-adolescent conflict did not have a significant relationship to depressive symptoms among Chinese and Korean adolescents.

Conclusion

This review of the literature illustrated an overview of depressive symptoms among ethnic minority male and female adolescents. As research has shown, ethnic minority adolescents are prone to higher levels of depressive symptoms (Brooks et al., 2002; Kubik et al., 2003; Moon & Rao, 2010; Roberts & Chen, 1995). Additionally, gender, parental psychological control, and family cohesion were influential determinants to depressive symptoms among minority adolescents (Dmitrieva et al., 2004; Greenberger

& Chen, 1996; Herman et al., 2007; Soenens et al., 2008). The next chapter will provide detailed information regarding this thesis' methods, the sample, and measurements used to assess depressive symptoms among ethnic minority adolescents.

CHAPTER III

METHODOLOGY

This thesis is connected to a larger research project titled “Adolescent Resiliency in Multi-Cultural Communities” (ARMCC). For the purpose of this thesis, secondary data analyses were conducted on the “Father’s Count” subproject using depressive symptoms, parental relationships, and family cohesion variables from the self-report survey that high schools students have completed. Specifically, the analyses for this thesis utilized data from participating adolescents. The principal investigators for the ARMCC and Father’s Count research project are Dr. Scott W. Plunkett and Dr. Tovah Sands from California State University, Northridge. Dr. Plunkett is a professor in the Department of Psychology. Dr. Sands is a professor in the Department of Educational Psychology and Counseling. Additional principal investigator include Dr. Andrew O. Behnke from North Carolina State University and Dr. Carolyn S. Henry from Oklahoma State University.

Primary investigators contacted administrators at various public high schools in California, Oklahoma, and North Carolina to request participation in the research project. Upon receiving approval to conduct the study at various high schools, the principal investigators contacted individual teachers, who gave consent to have their students participate in the research study. Parent consent forms were given to the students, and teachers were asked to collect the forms upon students’ return.

This chapter provides detailed description of the data collection procedures of the research. Additionally, the sample characteristics will be described. Lastly, the instruments used to conduct the study will be outlined.

Data Collection Procedures

In order to conduct the research study, permission was requested and received from the Office of Research and Sponsored Projects at California State University, Northridge. Approval for data collection was granted by the Committee for the Protection of Human Subjects. To participate in the research study, parent or guardians had to provide consent for the involvement of the adolescent. Once parent and guardian consent forms were returned, the research team arranged with the schools to administer the self-report surveys. Adolescent consent was required before participants could start the self-report survey. The research team members explained the procedures in completing the self-report surveys and were available to answer any participant questions. The researchers explained to the participants that the survey would take approximately 30-45 minutes to be completed in the classroom and all responses would be confidential and anonymous. Once the participants signed the assent form, they began completing the questionnaire. The research team members remained in the classrooms to answer any questions participants may have had. Once the surveys were completed, the research team collected and placed them in an envelope and delivered them to a research office at the university for data coding, entry, verification, and analyses. The survey data were coded and then entered in Excel. The Statistical Package for the Social Sciences (SPSS) software was used for the data analyses.

Sample Characteristics

This research study consisted of 949 participants from high schools in California, Oklahoma, and North Carolina. With regard to participants in each state, 53.3% ($n = 506$) resided in North Carolina, 41.5% ($n = 394$) in California, and 5.2% ($n = 49$) in

Oklahoma.

Among the participants, there were 502 females and 447 males who were between the ages of 12-18 year olds ($M = 15.11$, $SD = .96$). The sample was composed of 60.3% ($n = 572$) of adolescents who identified as Hispanic/Latino, 25.6% ($n = 243$) as African-Americans, 3.5% ($n = 33$) as Caucasian/White who came from immigrant families, 2.5% ($n = 24$) who identified as Asian, 1.1% ($n = 10$) as Native American, and 5.9% ($n = 56$) who identified as mixed race.

Since this study examines family cohesion, researchers were interested in the current living situation of the participants. Nearly 53% ($n = 503$) of participants lived with both birth mother and father, while 18.8% ($n = 178$) lived with birth mother only, and 2.2% ($n = 21$) lived with only their birth father. Additionally, 13.3% ($n = 126$) lived with their birth mother and stepfather, and 2.4% ($n = 23$) lived with their birth mother and her boyfriend. Furthermore, 1.6% ($n = 15$) lived with their birth father and stepmother, and .9% ($n = 9$) lived with their birth father and his girlfriend. Lastly, .7% ($n = 7$) of participants reported living with their adoptive parents, and 3.6% ($n = 34$) stated other as their living situation.

Instruments

The instrument used to gather data was a self-report survey. The self-report survey was comprised of statements about the adolescents' perceptions of their parental relationships, family cohesion, and depressive symptoms. The survey consisted of 14 demographic questions, such as age, grade, gender, and whom the participants resided with.

To determine the level of adolescent depressive symptoms, participants rated 10 statements from the short-version (Kohout, Berkman, Evans, & Cornoni-Huntley, 1993) of the Center for Epidemiologic Study's Inventory for depressed mood (Radloff, 1977). The response category for these statements were based on a Likert scale where 0 = rarely or none of the time (less than 1 day), 1 = some or a little of the time (1-2 days), 2 = occasionally (3-4 days), and 3 = mostly or almost all of the time (5-7 days). Participants were asked to, "How often have you felt the following ways during the past SEVEN DAYS." Sample items included, "I felt depressed," and "I felt that everything I did took a lot of effort."

To measure parental psychological control, participants rated eight statements about their mothers and fathers separately (Bush, Peterson, Cobas, & Supple, 2002). The response category for these statements were based on a Likert scale of 1 = strongly disagree, 2 = disagree, 3 = agree, and 4 = strongly agree. A sample item follows: "This parent avoids looking at me when I have disappointed him/her".

To measure family cohesion, participants were asked to rate nine statements (Moos & Moos, 1994). The response category for these statements were based on a Likert scale where 1 = not true, 2 = generally not true, 3 = generally true, and 4 = true. Sample items included, "Family members really help and support one another," and "We often seem to be killing/wasting time at home."

CHAPTER IV

RESULTS

The present study sought to examine the relationship between parental psychological control, and minority adolescents' level of depressive symptoms while examining gender as a moderator. This chapter discusses the results of the study and the data analyses that were conducted. Data were analyzed using independent t-tests, Pearson correlations, and hierarchical multiple regressions. The results for each hypothesis are discussed and elaborated in further detail.

Independent Samples T-Test Examining Differences Between Genders

The first hypothesis is that minority adolescent girls will report significantly higher depressive symptoms than boys, and that significant differences between boys and girls will be found on family cohesion and parental psychological control. Independent samples t-tests were conducted to examine the difference between genders on parental psychological control, family cohesion, and depressive symptoms. Results found no difference between genders on parental psychological control or family cohesion. However, significant difference was found between genders on depressive symptoms ($t = -4.30, p < .001$). Specifically, girls ($M = .84, SD = .55$) reported significantly higher depressive symptoms than boys ($M = .68, SD = .60$).

Pearson Correlations

The next research hypotheses stated that adolescents' perceptions of their family cohesion will be significantly and negatively related to depressive symptoms and that perceptions of parental psychological control will be significantly and positively related to depressive symptoms. Bivariate correlations were conducted to examine the strength

and direction of the relationship between parental psychological control, family cohesion, and depressive symptoms (see Table 1). Correlations indicated that parental psychological control had a significant and positive relationship to depressive symptoms ($r = .24, p < .001$). The correlations also showed that family cohesion had a significant and negative relationship to depressive symptoms ($r = -.41, p < .001$).

Table 1
Bivariate Correlations

	1	2	3	4
1. Depression	1.00			
2. Parental Psychological Control	.24**	1.00		
3. Family Cohesion	-.41**	-.20**	1.00	
4. Gender	.14**	-.05**	-.54*	1.00

* $p < .05$. ** $p < .01$. *** $p < .001$.

Boys = 0, Girls = 1.

Hierarchical Multiple Regressions

The last research hypothesis stated that the relationship between family cohesion, parental psychological control, and depressive symptoms would vary based on gender of the youth. A hierarchical multiple regression analysis was conducted to examine the contribution of the predictor variables to the variance in depressive symptoms and to test potential moderation by gender (See Table 2). First, the predictor variables were centered, and then the interaction terms were calculated. In the first step, parental psychological control and family cohesion were entered into the regression equation. Then, gender was entered into the equation to see if gender accounted for significant variance above and beyond parental psychological control and family cohesion. In the third step, the interaction terms were entered (i.e., parental psychological control x gender, family cohesion x gender) to see if they accounted for any additional variance in depressive symptoms. In the first step, it was found that parental psychological control

and family cohesion accounted for a significant amount of variance in depressive symptoms ($R^2 = .19, F = 104.72, p < .001$). The beta coefficients indicated that parental psychological control was significantly and positively related to depressive symptoms ($Beta = .16, p < .001$), while family cohesion was significantly and negatively related to depressive symptoms ($Beta = -.37, p < .001$). In the second step of the hierarchical multiple regression analysis, gender contributed an additional 1.70% of the change in depressive symptoms ($F = 19.46, p < .001$). The beta coefficients in step 2 indicated that parental psychological control was significantly and positively related to depressive symptoms ($Beta = .16, p < .001$), family cohesion was significantly and negatively related to depressive symptoms ($Beta = -.37, p < .001$), and gender was significantly and positively related to depressive symptoms ($Beta = .13, p < .001$). In step 3, the interactions between gender and parental psychological control and family cohesion did not account for any additional variance in depressive symptoms (R^2 change = .00, $F = .02, p = .98$). The beta coefficients in step 3 indicated that parental psychological control was significantly and positively related to depressive symptoms ($Beta = .16, p < .001$), family cohesion was significantly and negatively related to depressive symptoms ($Beta = -.36, p < .001$), and gender was significantly and positively related to depressive symptoms ($Beta = .13, p < .001$). Since the interaction terms were not significant, the last hypothesis regarding moderation by gender was not supported.

Table 2

Hierarchical Multiple Regression

	B	Error	Beta	R ²
Step 1				
Parental Psychological Control (PPC)	.14	.03	.16***	
Family Cohesion (FC)	-.41	.03	-.37***	.19***
Step 2				
Parental Psychological Control	.15	.03	.16***	
Parental Psychological Control	-.40	.03	-.37***	
Gender	.15	.04	.13***	.20***
Step 3				
Parental Psychological Control	.15	.04	.16***	
Parental Psychological Control	-.39	.05	-.36***	
Gender	.15	.04	.13***	
Psychological Control x Gender	-.01	.07	-.01	
Cohesion x Gender	.04	.06	.00	.20***

* $p < .05$. ** $p < .01$. *** $p < .001$.

Boys = 0, Girls = 1.

CHAPTER V

DISCUSSION

This chapter will summarize and discuss the results of the present study.

Additionally, this chapter will review the assumptions and implications of the study and recommendations for future research and practice. The purpose of the current study was to learn more about depressive symptoms among minority male and female adolescents. Previous research has shown that parental psychological control and family cohesion are influential factors related to depressive symptoms among minority adolescents (Moon & Rao, 2010; Needham, 2008). This thesis also focused on gender differences among minority adolescents. With regards to gender, previous literature has shown significant differences between the rates of depressive symptoms among female and male adolescents. Specifically, previous research has found that female adolescents report higher rates of depression than male adolescents (Nolen-Hoeksema, 2001; Rodhe et al., 2009).

Based on previous literature presented in Chapter 2, this thesis proposed four research hypotheses. The first hypothesis stated that minority adolescent girls will report significantly higher depressive symptoms than minority adolescent boys, and that significant differences between boys and girls will be found on family cohesion and parental psychological control. Consistent with previous research, the results of the current study revealed girls reported higher levels of depressive symptoms compared to boys (Rood, Roelofs, Bögels, Nolen-Hoeksema, & Schouten, 2009). One reason that girls report greater levels of depressive symptoms than boys can be related to their inclination to ruminate. Rumination relates to the one's thought process and focus on their depressed

mood and trying to understand the underlying meaning behind it (Nolen-Hoeksema, 1991). Research has shown that depressive symptoms are influenced by the rumination process, as well as by gender (Grant et al., 2004; Jose & Brown, 2008). Contrary to previous literature, there were no difference between genders among parental psychological control and family cohesion. The differences could be explained because most of the previous studies have focused on White, non immigrant populations. Also, many of the previous studies cited examined mothering and/or fathering, but not 'parenting' which combined mothers and fathers' responses together such as in this study. Future research should examine whether these factors make a difference.

The second research hypothesis stated that minority adolescents' perceptions of family cohesion would be significantly and negatively related to depressive symptoms. The results indicated that family cohesion had a significant and negative relationship to depressive symptoms. It was anticipated that lower levels of family functioning would be associated to higher levels of depressive symptoms. Essentially, how the adolescent perceives the relationship of their family dynamics influences the likelihood of depressive symptoms. Among certain cultures, the perception of family cohesion may have a different effect on adolescent depressive symptoms. For example, research has shown lower levels of family cohesion have a substantial influence on African American adolescents (Herman et al., 2007). On the other hand, research has shown higher levels of family conflict among European American adolescents, is associated with depressive symptoms (Herman et al., 2007). Reducing family conflict may not be sufficient in lessening depressive symptoms for the adolescent (Herman et al., 2007). Family conflict may bring upon additional stressors, which can indirectly activate depressed moods.

The third research hypothesis was that minority adolescents' perceptions of parental psychological control would be significantly and positively related to depressive symptoms. The results showed that parental psychological control had a significant and positive relationship to depressive symptoms. In hindsight, it was projected when parents engage in less psychological controlling behaviors, adolescents would report lower levels of depressive symptoms. Adolescents' perceptions of their parents inadvertently affect how they view themselves (Plunkett, Henry, Robinson, Behnke, & Falcon, 2007). Adolescents who perceive their parents reflecting negative attributes (such as through love withdrawal, guilt, and other psychologically controlling behaviors) will likely perceive themselves in a negative manner. This level of cognitive thinking may increase depressive moods and symptoms. Lastly, adolescents may perceive psychological control as an indirect measure to the parental figures' love and affection (Barber, 1996).

The last research hypothesis stated the relationship between family cohesion, parental psychological control, and depressive symptoms will vary based on the gender of the youth. Based on the hierarchical multiple regression analyses, gender was not a significant moderator of the relationship between parental psychological control, family cohesion, and depressive symptoms. It appears that gender is only directly related to depression, with girls reporting significantly higher depression than boys.

Assumptions

This research study was created based upon certain assumptions. Researchers involved in this study assumed that all participants involved were not influenced by the researchers. The researcher made the assumption that all participants were able to comprehend English and answer the research questionnaire thoroughly since they were

attending schools in the United States where the language of instruction was English. It was also assumed that the measures used in this study were designed and appropriate for adolescents from racial and ethnic groups since the measures have been used with ethnic minorities in the past and had good reliability and validity. Lastly, the researcher ensured that no errors were made in the data coding and entry through training of the research assistants.

Limitations

This study contained limitations that should be noted. One limitation that should be considered is that the sample only included adolescents whose parents gave consent for participation in the study. Some parents may not have wished for their child to participate due to the questions asked in the survey. Also, adolescents could have felt uncomfortable asking for parental consent knowing the nature of the study. Thus, the sample may not be generalizable to all minority adolescents.

Another limitation to the study was the lack of diversity among the minority adolescents. While minority adolescents were grouped as a collective in this thesis study, the sample of this study consisted of over 85% of adolescents who identified as Hispanic/Latino and African American/Black. This sample contained only 24 people who identified as Asian and 33 participants identified as Caucasian/White from immigrant families (e.g., Armenian, Persian). Furthermore, a diverse Asian population would allow for results to be better generalized to this population.

Next, this study used cross-sectional data, thus it is difficult to know for sure the direction of the relationships between the variables. It is possible that depression predicts adolescents' reports of parental psychological control and family cohesion, and/or that

the relationships are reciprocal. Longitudinal studies would be necessary to determine direction of the relationships.

Recommendations for Research and Practice

The results of this study provide insight in learning more about depressive symptoms among minority adolescents. While this study focused on overall parental psychological control, a recommendation for future research would be to individually assess paternal and maternal psychological control and the impact each has on depressive symptoms among minority adolescents.

In this thesis research, family cohesion was measured as a collective unit of the family. In the future, researchers may provide additional statements where adolescents could rate how each family member contributes to the dynamics of the overall family and how that influences the adolescent. Specifically, the relationship that adolescents have with siblings and other individuals who reside with the adolescent could be assessed.

Among minority families, little research has been conducted on Middle Eastern adolescents in the United States. It would be interesting to explore depressive symptoms of adolescents in the Middle Eastern communities. In addition, future studies should examine whether differences exist between first and second generation immigrant families.

Lastly, researchers could ask questions regarding how friends and peers influence depressive symptoms among adolescents. Outside of the home, children and adolescents spend a substantial amount of time with peers. Relationships with peers and social interaction can play an influential role in the life of an adolescent.

The results of this study suggest implications for practitioners such as psychologists, marriage and family therapists, and other mental health professionals working with minority adolescents. Practitioners can help guide parents to gain an understanding of how their controlling behaviors ultimately have a direct and indirect influence on the adolescent and depressive symptoms. Mandara and Pikes (2008) state that parents should find a balance in helping their children go through their own experiences, yet sustaining structure and rules within the household. With regard to family cohesion, helping parents provide a positive environment and establishing stronger connections within the family helps alleviate depressive symptoms (Herman et al., 2007). As a result of forming positive relationships by parents and within the family, it can help reduce the likelihood of depressive symptoms among adolescent girls.

Conclusions

Depressive symptoms have a significant impact in the life of the adolescent and the overall family. It is important to gain an understanding of how depression and depressive symptoms influence the lives of adolescents and their parents and families, especially among ethnic and racial minorities. This study demonstrated that gender, parental psychological control, and family cohesion influence adolescent depressive symptoms in minority families.

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