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This study examined the relationship between familism and depressive symptoms across relational contexts in adolescence. Familism is characterized as a strong attachment to family, reciprocated loyalty and obligation, a subjugation of self to one's family, and maintenance of respect for parental desires and expectations. Most research finds that familism predicts fewer depressive symptoms. However, recent findings suggest that under some circumstances familism may not be protective. The current study extends past research by examining whether maternal depressive symptoms, maternal warmth and support, and peer and teacher support moderate the relationship between familism and depressive symptoms. One hundred and seventy-six Latino adolescents (52.9% female) in 7th- 10th grades and 70 of their mothers participated in this study. Overall, familism was associated with fewer adolescent depressive symptoms, even in the context of maternal depressive symptoms. However, maternal warmth and support moderated the relationship between familism and adolescent depressive symptoms such that familism was only protective at high levels of maternal warmth and support. Peer and teacher support was also a moderator: at low levels of peer and teacher support familism was related to fewer adolescent depressive symptoms. In the context of high peer and teacher support, adolescents reported low depressive symptoms regardless of familism.

RISK AND RESILIENCE PROCESSES, FAMILISM,
AND DEPRESSSIVE SYMPTOMS
IN LATINO ADOLESCENTS

by

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TABLE OF CONTENTS

	Page
LIST OF TABLES	iv
LIST OF FIGURES	v
CHAPTER	
I. INTRODUCTION	1
II. METHOD	21
III. RESULTS	27
IV. DISCUSSION	32
REFERENCES	45
APPENDIX A. TABLES AND FIGURES	58

LIST OF TABLES

	Page
Table 1. Correlations and descriptive statistics.....	58
Table 2. Linear regression model evaluating the relationship between familism and adolescent depressive symptoms controlling for age and gender.....	59
Table 3. Hierarchical linear regression models evaluating maternal warmth and support and peer and teacher support as moderators of the association between familism and adolescent depressive symptoms	60
Table 4. Maternal depressive symptoms as a moderator of the association between familism and adolescent depressive symptoms	61

LIST OF FIGURES

	Page
Figure 1. Maternal warmth and support moderating the relationship between familism and adolescent depressive symptoms	62
Figure 2. Peer and teacher support moderating the relationship between familism and adolescent depressive symptoms.....	63

CHAPTER I

INTRODUCTION

Latino adolescents experience higher rates of depressive symptoms than other ethnic groups (Twenge & Nolen-Hoekema, 2002). Indeed, the Centers for Disease Control and Prevention's Youth Risk Behavior Surveillance System (2009) found that 31.6% of Latino high school students reported feeling sad or hopeless almost every day for 2 weeks or longer in the past 12 months compared to 27.7% of African American and 23.7% of European American students. Another study found that adjusting for age, gender, perceived health, and occupation of the primary wage earner in the household, Mexican American adolescents reported more depressive symptoms than European American adolescents (Roberts & Sobhan, 1992). Given these statistics, it is important not only to evaluate why Latino adolescents are more likely to develop depressive symptoms compared to other ethnicities, but also why many Latino adolescents are resilient despite their heightened risk.

Because the family unit is an integral part of Latino adolescents' lives, research has focused on understanding the role of culture-specific family dynamics in the development of depressive symptoms. The majority of this research has focused on the protective role of familial cultural values since Latinos place a high value on their family and rely more on their family for support compared to other ethnic groups (Calzada,

Tamis-LeMonda, & Yoshikawa, 2012). However, given that American culture stresses autonomy and independence from one's family while Latino culture emphasizes more collective socialization practices (Smokowski, Rose, & Bacallao, 2010), these cultural values may not always align with the larger US cultural context and may confer risk. In fact, past research on familial cultural values and depressive symptoms is limited and yields mixed results (Smokowski & Bacallao, 2007; Kulberg, Peña, & Zayas, 2010). Thus, more research is necessary to understand the role of familial cultural values in the development of depressive symptoms in Latino youth.

The familial cultural value that has received the most attention in the literature is familism. Cooley (2001) suggests familism is the “most important factor influencing the lives of Latinos” (p.130). Familism is defined as a strong attachment to family, reciprocated loyalty and obligation, a subjugation of self to one’s family, and maintenance of respect for parental desires and expectations (Steidel & Contreras, 2003). There are three dimensions of familism: (1) the attitudinal, characterized by dispositions, values, and beliefs that emphasize prioritization of the welfare of the family, interdependence, family support and obligations; (2) the behavioral, everyday actions and decisions that are strongly influenced by one’s attachment to one’s family; (3) the structural, physical proximity and time spent with extended family (Valenzuela & Dornbusch, 1994; Sabogal, Marin, Otero-Sabogal, & Marin, 1987; Steidel & Contreras, 2003).

This study will only examine attitudinal familism, which is consistent with the majority of literature examining familism in adolescence. The attitudinal component of familism may be particularly salient for adolescents as they are beginning to define their own belief systems. In this developmental stage, the ability to think abstractly emerges and individuals begin to think critically about the values socialized by their parents and either internalize or reject them (Deci & Ryan, 1985). Thus, at this stage, adolescents are able to more fully express their own beliefs regarding their current and future roles in their family. These measures allow researchers to capture the extent to which the value of familism is internalized and how much adolescents feel like they “should” value these components of familism. In this way, researchers can understand how the internalization of these cultural values impact adolescents’ psychosocial functioning.

Theoretical Framework

Although there is a fairly large literature on the role of familism in the lives of Latinos, the majority of this research has failed to examine familism from a developmental psychopathology perspective. Developmental psychopathology focuses on integrating the biological, psychological and social-contextual aspects of normal and abnormal development (Cicchetti, 2006). Developmental pathways or trajectories are probabilistic rather than deterministic and certain mechanisms (e.g. relational contexts) can increase or decrease the likelihood of developing a psychopathology (e.g. depressive symptoms). Risk and protective factors are viewed as processes that can change over time and in different contexts rather than stagnant variables. In this way, familism may

be protective against internalizing symptoms in some relational contexts, but not in others. Vulnerabilities increase the probability a particular child will succumb to risk and potentiating factors exacerbates the impact of a risk (Sroufe & Rutter, 1984). For example, the absence of supportive relationships may be a vulnerability that exacerbates the increased risk Latino adolescents already have for developing depressive symptoms. The majority of past research has measured familism in a static way ignoring the contextual factors that may influence its effects (Smokowski & Bacallao, 2007; Gamble & Modry-Mandell, 2008; German, Gonzales & Dumka, 2008; Gil, Wagner, & Vega, 2000; Horton & Gil, 2008; Contreras, Lopez, Rivera-Mosquera, Raymond-Smith, & Rothstein, 1999).

From a developmental psychopathology perspective, psychopathologies are viewed as “normal development gone awry” with normal and abnormal behavior viewed on a continuum (p. 1). An individual can move between normal and abnormal functioning at different points in development and whether an individual develops a psychopathology depends on the interaction between his or her environment and genetic predisposition (Kerig & Wenar, 2006). In this way, familism may interact with the heightened risk Latino adolescents have to developing depressive symptoms and whether adolescents succumb to this vulnerability may depend on the specific relational contextual factors in the adolescent’s life. Sroufe and Rutter (1984) emphasize taking a holistic approach to human development, viewing development as hierarchical with individuals facing changing stage-salient issues throughout development. As mentioned,

familism may be particularly salient in adolescence as the ability to think abstractly develops allowing individuals to think critically about the values socialized by their parents and either internalize or reject them (Deci & Ryan, 1985).

The concepts of equifinality and multifinality are also important characteristics of a developmental psychopathology perspective. Equifinality suggests a number of different pathways can lead to the same outcome (e.g. a number of different contexts may lead to the development of depressive symptoms). Multifinality is that a specific risk or protective mechanism may have different developmental implications depending on the context and individual factors (e.g. the relationship between familism and depressive symptoms may be influenced by relational contexts) (Sroufe & Rutter, 1984; Kerig & Wenar, 2006).

Familism and Depressive Symptoms

Theoretically, multiple mechanisms may account for the protective role of familism in the prediction of depressive symptomatology. First of all, adolescents who value familism report greater feelings of connectedness and cohesion with the family and better parent-child communication (Fuligni, Tseng & Lam, 1999). It may be this experience of closeness with parents and family that makes familism protective against depressive symptoms (Cumsille & Epstein, 1994). Second, adolescents with high familism may have lower parent-adolescent conflict because their values are more consistent with their parents (Smokowski & Bacallao, 2007). Adolescents who value familism less than their parents may not be as willing to make sacrifices for their family

as their parents expect and this may lead to parent-adolescent conflict (Telzer, 2010). Third, the family obligations component of familism may give adolescents a sense of identity and purpose during a developmental period that is ambiguous in American society (Fuligni, 1998). This could lead to a higher level of positive well-being and fewer depressive symptoms (Fuligni et al., 1999). Finally, adolescents with high familism tend to have a greater respect for parental authority and conformity to parents' wishes (Ghazarian, Supple & Plunkett, 2007). Respecting parental authority may lead to less parent-adolescent conflict and in turn fewer depressive symptoms for the adolescents.

However, countering the view that familism is protective, other researchers have argued that high levels of familism may correlate with higher internalizing symptoms in Latina adolescents. According to the *problem suppression-facilitation model*, female adolescents with higher familism may be restricted from deviating from parents' values, attitudes, beliefs and practices causing a turning inward resulting in higher internalizing symptoms, lower self-esteem, depression and suicidality (Polo & López, 2009; Weisz et al., 1988). Females with high familism may also be more sensitive to conflict in the family (Kuhlberg et al., 2010). Also, adolescents with high familism may face more challenges as their beliefs do not align with the US cultural context and this may lead to or exacerbate parent-adolescent conflict (Smokowski et al., 2010).

Although few studies have examined these specific mechanisms, the majority of previous research on familism does find that it confers protective effects across

outcomes. With regard to depressive symptoms, both concurrent and longitudinal studies emphasize the protective role it plays against depressive symptoms (Smokowski & Bacallao, 2007; Smokowski & Bacallao, 2009; Smokowski et al., 2010; Ayón, Marsiglia, Bermudez-Parsai, 2010). Similarly, other studies have shown familism is associated with numerous other positive youth outcomes such as fewer behavioral problems (Gamble & Modry-Mandell, 2008; German et al., 2009), decreased rates of substance use (Gil et al., 2000; Horton & Gil, 2008), and better psychological adjustment (Contreras et al., 1999).

However, recent research suggests that under some contexts familism may be associated with negative outcomes and may even increase the likelihood of developing depressive symptoms in Latino adolescents (Baumann et al., 2010; Smokowski & Bacallao, 2007). The developmental context that has received the greatest research attention has been the congruence on cultural values between children and their parents, typically termed an “acculturation gap.” Acculturation is a complex process where immigrants come into contact with a new culture and their beliefs, values, and behaviors may change as a result. Immigrants are faced with the challenge of becoming culturally compatible with a new culture while retaining the cultural values of their native culture.

According to the acculturation gap literature, adolescents tend to acculturate relatively faster than their parents and this leads to an “acculturation gap” in that adolescents are relatively high in acculturation while their parents are relatively low. Acculturation theory posits that this gap leads to or exacerbates parent-child conflict (Pasch, Deardorff, Tschanne & Penilla, 2006; Vega, Gil, Warheit, Zimmerman, &

Apospori, 1993). In fact, parent-adolescent gaps in familism values (mothers reporting higher levels of familism than their daughters) are risk factors for depressive symptoms (Kuhlberg et al., 2010). Gaps in familism between parents and their adolescent children precipitate stress in Latino families (Baumann et al., 2010). Zayas, Bright, Álvarez-Sánchez, and Cabassa (2009) found girls who attempted suicide did not differ on familism compared to girls that had not attempted suicide, but the gap between daughters' and mothers' familism values was higher for adolescents who had attempted suicide compared to those who had not attempted.

Consistent with the problem suppression-facilitation model, a handful of studies document that familism is a risk factor in other contexts as well. For example, Kuhlberg et al. (2010) found familism was associated with lower levels of parent-adolescent conflict, but higher levels of internalizing behaviors in a sample of adolescent Latinas, 50% of whom had histories of suicide attempts. Self-esteem and internalizing behaviors mediated the relationship between parent-adolescent conflict and suicide attempts. This study suggests that familism may be a risk mechanism in the context of high psychological distress. The samples of female Latinas in the aforementioned study were females who had attempted suicide thus representing a severely at-risk population, and the results of these studies may not generalize to those at lesser risk. Nonetheless, this study indicates familism may be a risk mechanism in certain types of contexts (e.g., in the presence of adolescent psychopathology) (Kuhlberg et al., 2010).

Another context in which familism may fail to serve as a protective mechanism is at high levels of discrimination. Umaña-Taylor et al. (2011) found that for Mexican-adolescent mothers familism was protective against the negative effects of discrimination on risk-taking behaviors at low levels of discrimination, but not at high levels of discrimination. A similar study by Delgado, Updegraff, Roosa, and Umaña-Taylor (2009) showed that girls with mothers with high familism values had greater perceived discrimination and more deviant peer affiliations than girls whose mothers had lower degrees of familism.

Given the empirical evidence that the relationship between familism and depressive symptoms can change depending on the context, the proposed study will aim to better understand the risk and resilience processes surrounding this familial cultural value. This study will examine the main effect of familism and depressive symptoms in this sample of Latino adolescents from a developmental psychopathology perspective. It will also evaluate multiple relational contexts in adolescents' lives (e.g. maternal depression, maternal warmth and support, and peer and teacher support) to see the moderating effect these environments have on the relationship between familism and depressive symptoms.

Familism and Maternal Depressive Symptoms

Although a substantial amount of research has been done on the relationship between maternal depressive symptoms and negative youth outcomes in European American families, little research has examined the role of this risk factor in Latino

families. In European American adolescents, maternal depressive symptoms are associated with many adolescent adjustment problems such as a greater risk for internalizing and externalizing disorders and lower family satisfaction (Hammen & Brennan, 2003; Marmorstein & Iacono, 2004). Also, women with depression have more difficulty parenting and communicating with their children (Goodman & Gotlib, 2002). Despite the fact that maternal depressed mood puts adolescents at a greater risk for internalizing and externalizing disorders, many children are resilient to developing psychopathology (Brennan, Brocq & Hammen, 2003).

The limited studies focusing on Latina maternal depressive symptoms, mother-child relationship, and child outcomes are equivocal (La Roche, Turner, & Kalick, 1995). A study by Ruttenberg, Finello, and Cordeiro (1997) found that Latina mothers with depression did not interact differently with their infants during a feeding scenario than Latina mothers not struggling with depression. Contrarily, Planos, Zayas, and Busch-Rossnagel (1997) showed that Latina mothers without depression praised their children more and gave less negative verbal feedback compared to Latina mothers with depression. Corona, Lefkowitz, Sigman, & Romo (2005) found that maternal depressive symptoms were related to greater parent reported youth internalizing and externalizing symptoms in a sample of 111 Latina mothers-adolescent dyads. However, maternal depressive symptoms were not significantly associated with adolescent reported internalizing or externalizing symptoms. Maternal depressive symptoms were associated with maternal report of family satisfaction, but not adolescent report of satisfaction.

Furthermore, maternal depressive symptoms were not related to outsiders' ratings of maternal behavior during a conflict conversation (Corona et al., 2005). Taken together these studies suggest that maternal depression may be a risk factor for Latino adolescents' psychological outcomes as a mother struggling with depression may not be as attentive to her adolescent child, but the evidence is not as consistent for this compared to findings with European American families.

A critical component of familism is the reciprocal nature of the family relationship. Each member of the family is expected to put the family's needs before their own (Steidel & Contreras, 2003). A mother with depression may be unable to fulfill her family obligations, and this may lead to her children taking over many of the responsibilities for the family. Maternal depressive symptoms may be more detrimental to psychological functioning for an adolescent with a high familism value. For example, for an adolescent who believes this reciprocal relationship is important, having a mother who is experiencing depressive symptoms may be more inconsistent with their world-view. The adolescent may feel more pressure to support his or her family and may feel more burdened by this task than in a low familism household. This may lead to the adolescent experiencing more depressive symptoms. Moreover, feeling close and connected with someone who is depressed might make one feel more depressed (Rose, 2003). While the family unit may benefit from having an adolescent with high familism values, when the mother is experiencing depressive symptoms because the family may be

better “held together,” this might be at the expense of the adolescents' psychological well-being (Kuperminc, Jurkovic & Casey, 2009).

Similar to the notion that familism may sometimes be burdensome when a relationship lacks reciprocity, familism may also not be protective against internal family stressors. Hernández, Ramírez García, & Flynn (2010) measured parent-child discord, threat appraisals of parent-child discord, and psychological distress. Threat appraisals are evaluations of “how much harm a stressor is likely to impose on the individual’s well-being.” Results show that the relation between parent-child discord and threat appraisals was significantly stronger at higher than at lower levels of familism. Furthermore, threat appraisals partially mediated the association between parent-child discord and psychological distress. Familism may buffer the effects of stressors external to the family context, but stressors internal to the family context may become risk mechanisms because “intrafamilial discord violates the high expectations of family harmony that are tied to familism” (Hernández et al., 2010). Since maternal depression can be viewed as an internal family stressor, familism may not be protective against adolescent internalizing symptoms in this context.

No research has examined the relationship between maternal depressed mood, familism, and adolescent depressive symptoms. Given the research that has shown familism fails to be protective against internal family stressors, familism may be a protective process when parents are psychologically healthy, but a risk process when the mothers are struggling with depressive symptoms. Maternal depressive symptoms may be

more detrimental for adolescents with high familism values because the family unit is so important to them. Hernández et al. (2010) suggested that the greater the importance of a value, the greater negative impact failing to adhere to the given value will have on psychological outcomes. If a value is not important, lack of adherence to “such a value will not be consequential” (Hernández et al., 2010). The proposed study will be the first known study to examine the relationship between maternal depressive symptoms, familism, and adolescent depressive symptoms.

Maternal Warmth and Support

For an adolescent with high familism, having a positive relationship with his or her mother may be more protective against depressive symptoms compared to an adolescent with low familism. Likewise, the lack of good mother-adolescent relationship may be more detrimental to an adolescent that has endorsed a strong value of familism. While familism is a cultural value characterized by a strong attachment to family, reciprocal loyalty and obligation, subjugation of self to one’s family, and maintenance of respect for parental desires and expectations, a positive mother-adolescent relationship in this study will be conceptualized by the adolescents’ perception of maternal warmth and support. Research has shown that maternal warmth and support are central to positive mother-adolescent relationships (Rueter & Conger, 1995).

Although few studies have been done with Latino adolescents living in the U.S., studies across cultures have found perceived parental support to be protective against psychological distress as well as depressive symptoms more specifically (Boutelle et al.,

2009; Needham, 2008; Sheeber, Hops, Alpert, Davis & Andrews, 1996; Auerbach, Bigda-Peyton, Eberhart, Webb, & Ho, 2011). Previous research has shown adolescents in less supportive and more conflictual family environments had greater depressive symptomatology both concurrently and prospectively over a 1 year period (Sheeber et al., 1996). Another study by Bogard (2005) also found perceived parental support to be associated with lower levels of depressive symptoms. Other studies have examined the direction of this association and found greater parental social support predicted less depressive symptoms (Boutelle et al., 2009; Needham, 2008; Sheeber et al., 1997; Auerbach et al., 2010). Likewise, Stice, Raga and Randall (2004) found that lower parental support predicted increase in depressive symptoms as well as the onset of major depression after a stressful life event. In a sample of Latina adolescents, maternal support was negatively associated with mother-daughter conflict and depressive symptoms for both early and middle, Mexican-origin, female adolescents (Bámaca-Colbert, Gayles, & Umaña-Taylor, 2012). These studies all endorse an association between maternal support and fewer adolescent depressive symptoms.

In addition to a lack of parental support being problematic, low levels of parental warmth were also associated with higher psychological distress across samples of adolescents in Hong Kong, Australia, and the U.S. (Gorman-Smith, Florsheim, & Henry, 2000; Chiu, Feldman & Rosenthal, 1992). Multiple studies have found higher rates of depressive symptoms among youths of various U.S. ethnic groups who report low maternal warmth (Ge, Lorenz, Conger & Elder, 1994; Greenberger & Chen, 1996). In a

study specific to Latino adolescents, greater levels of parental affection and warmth was associated with fewer depressive symptoms (Behnke, Plunkett, Sands, Bámaca-Colbert, 2011). Consistently, Zayas et al. (2009) found that adolescents that had attempted suicide in the past reported significantly less maternal warmth compared to adolescents with no previous suicide attempts. Since multiple studies have found a negative association between maternal warmth and depressive symptoms across various cultures of adolescents, we would expect a similar relationship in Latino adolescents.

Although much research has found maternal warmth and support to be protective against depressive symptoms, previous research has failed to look at whether maternal warmth and support enhances the relationship between familism and depressive symptoms. The lack of maternal warmth and support may increase the probability that an adolescent will develop depressive symptoms, especially for a child who greatly values family connectedness. For example, in the context of a warm and supportive mother-adolescent relationship, adolescents may perceive family obligations and subjugation of self to the family, two main components of attitudinal familism, as a way to help their mother with their family. An adolescent that has such a relationship, would be more likely to view the sacrifices they make for their family in a positive way (e.g. making them feel important and needed). Contrarily, an adolescent that does not have a warm, supportive relationship with their mother, may view these sacrifices as burdensome and this may lead to greater depressive symptoms.

Familism and Peer and Teacher Support

In addition to maternal support and warmth possibly enhancing the relationship between familism and depressive symptoms, peer and teacher support could also enhance this relationship. Adolescence is a period in which there is an expansion of peer networks; close friendships as well as peer crowd affiliation become more important aspects of peer relations (Kuttler, La Greca & Prinstein, 1999). For European American adolescents, close friends begin to surpass parents as adolescents' primary source of social support (Furman & Buhrmester, 1992). Latino adolescents are faced with negotiating these close relationships with peers as well as maintaining close social ties with their parents and families.

Previous research has neglected to examine the relationship between familism and support from others outside the family. Some research has examined the differential influences of family versus peer support on European American adolescents' outcomes, but this research has yielded mixed results. Colarossi & Eccles (2003) found that parent, teacher, and peer support each significantly predicted fewer depressive symptoms. Likewise, Rueger, Malecki & Demaray (2010) found parent, teacher, classmate, friend and school support to each to be significantly negatively correlated with depressive symptoms in a sample of 7th and 8th grade students from a large suburban middle school. However, Young, Berenson, Cohen & Garcia (2005) did not find parent and peer support to be related to depression, but did find that there was a significant interaction between the two support variables (i.e. parent support moderates the relationship between

anticipated peer support and depressive symptoms). Auerbach et al. (2010) found that classmate support, but not peer support, predicted fewer depressive symptoms. Other research has indicated that peer support did not significantly moderate the relationship between stress and depressive symptoms (Stice et al., 2004).

Taken together, these studies show that peer support tends to be related to fewer depressive symptoms, but not always. One possible reason that peer support has not been consistently associated with fewer depressive symptoms is that supportive peers might not always be a healthy influence as peers might pressure adolescents into deviant behavior. Peer relationships might be particularly difficult for Latino adolescents that are attempting to navigate the culture of their peer group and the culture of their families. These studies also found that combined support from parents and peers may be more protective against depressive symptoms than one source of support alone (Young et al., 2005). Adolescents who are able to form positive peer relationships and positive parent relationships simultaneously seem to benefit the most psychologically. In a similar way, peer support may bolster the relationship between familism and decreased depressive symptoms.

In addition to parents and peers, teachers also play an important role in adolescents' lives as they can often serve as confidants, mentors and friends (Lynch & Cicchetti, 1992). Research has shown that positive relationships with teachers in adolescence can lead to better psychological adjustment and a decrease in depressive symptoms. Roeser and Eccles (1998) found that positive teacher relationships were

associated with positive feelings of self-esteem and less anger and depressive symptoms. Changes in adolescents' perceptions of teacher support have been shown to predict changes in both self-esteem and depression. Perceived increases in teacher support were associated with decreases in depressive symptoms and increases in self-esteem (Reddy, Rhodes, & Mulhall, 2003). In a sample of 281 Latino immigrant youth from the ages of 12 to 19, support from teachers was associated with fewer depressive symptoms (Potochnick & Perreira, 2010). Teacher support may be more consistently associated with fewer depressive symptoms because teachers are more likely to exert a mature, positive influence on adolescents' lives compared to peers'. Since teacher support has consistently shown to be associated with fewer depressive symptoms, this may be a particularly salient relational context that may bolster the relationship between familism and depressive symptoms.

Although research has shown positive peer and teacher relationships to be related to fewer depressive symptoms, no research has looked at whether peer and teacher support can enhance the relationship between familism and depressive symptoms. Given that Latino adolescents must navigate the increasing importance of peer relationships while maintaining close relationships with their families, it is critical to better understand the relationship between familism, peer and teacher support and depressive symptoms. High levels of familism in some cases may interfere with the development of close peer relationships as spending too much time with their family or doing household chores may prevent such adolescents from spending time with their peer groups outside of school.

Latino adolescents who are able to have a balance between spending time with their peers and families may be the most psychologically healthy.

Goals and Hypotheses

In most cases, familism is a protective process associated with fewer depressive symptoms (Smokowski & Bacallao, 2007; Smokowski et al., 2009; Smokowski et al., 2010; Ayón et al., 2010). A key component of familism is the reciprocal relationship. In families where the reciprocal nature of familism is disrupted in some way (i.e. a mother is struggling with depressive symptoms), high levels of familism may increase the risk of an adolescent developing depressive symptoms. Few studies have looked at familism in a model of risk and resilience (Calzada et al., 2012). To my knowledge, not only have no previous studies have examined maternal depressive symptoms, maternal warmth and support, and peer and teacher support as moderators of familism and depressive symptoms, no previous research has examined the relationship of each of these contexts with familism. Furthermore, there is limited research examining if familism is protective over and above other positive family environment characteristics such as maternal warmth and support as well as how familism interacts with contexts outside of the family such as peer and teacher support. The goal of this project is to examine a model of risk and resilience with familism and depressive symptoms. In other words, how does the relationship of attitudinal familism and depressive symptoms change in different contexts in adolescence?

Informed by previous research in this area, I hypothesized that (1) higher levels of familism values will be associated with fewer adolescent depressive symptoms; (2) maternal depressive symptoms will moderate the relationship between familism and adolescent depressive symptoms in that at higher levels of maternal depressive symptoms, familism will be a risk factor and be associated with greater adolescent depressive symptoms (3) maternal warmth and support will also moderate the relationship between familism and depressive symptoms (i.e. at low maternal warmth and support, familism will fail to be significantly negatively associated with depressive symptoms); (4) teachers and peer support will strengthen the negative association between familism and depressive symptoms.

CHAPTER II

METHOD

Participants

Latino youth were recruited in all 7th, 8th, 9th, and 10th grade classrooms from three schools in North Carolina (two middle schools and one high school). There were 442 Latino students total among the three schools. Of the 442 students' families, 425 were recruited on the phone while 17 families were approached at an open house. Of the 17 students who consented at the open house, 14 students eventually participated in the study. Of the parents who were contacted over the phone, 221 parents consented to have their child participate (79% of those reached; 50% of total), and 161 parents consented to complete parent interviews (57.5% of those reached; 36% of total) and 40 parents declined to have their child participate (14% of those reached; 9% of total).

All of the Latino parents also received a bilingual recruitment letter and consent form that was sent home with their child from school; seven consents were returned to the main office and collected. The researchers were unable to contact 164 families (37% of total) due to disconnected numbers and inability to reach the parents. One hundred and ninety one students assented and participated in the current study (52.9% female). One student withdrew from the study. Fourteen of the students' surveys were unable to be included in the analyses because of incomplete data on one or more of the variables of

interest in this study. The final sample consisted of 176 adolescents (63% of those reached; 40% of the total population). Out of the 161 parents that originally consented, 89 parents completed interviews (55%). Missing data analyses revealed the participants with missing data were not significantly different on any of the variables of interest. Eighty-one mothers, five fathers, one grandmother, one grandfather, and one female guardian completed interviews. Because this was a study of maternal relationship variables, only the mother's interviews were used in the current study. Eleven of the mother's interviews were unable to be used due to incomplete data. The final sample consisted of 70 mothers (26% of those reached; 17% of total).

The mean age of the participants was 14.02 years. The community from which the sample was drawn was an emerging Latino community. Thus, 75 of the participants were not born in the United States (39.7%) and of those foreign born 66.7% immigrated before age 5. Furthermore, about 95% of the participant's parents were not born in the United States. The sample consisted of adolescents from Mexican (78%), Latino mixed (parents from different countries of origin; 8%), Nicaraguan (2%), Dominican (2%) and Salvadorian (2%) backgrounds. Other individuals identified were from Guatemalan, Colombian, Costa Rican and Cuban backgrounds.

Procedure

All survey administration was completed in the participating schools' cafeterias in the fall of 2010, during class periods determined by the principal and the teachers. The

participants had the option to have an English or Spanish version of the survey. Only one student chose to take the survey in Spanish. Measures not available in Spanish were translated and back translated, and then the research team resolved discrepancies jointly. The team also encouraged participants to ask for assistance at any point during the survey and checked each questionnaire to ensure the quality of the data. The parents were interviewed via phone in the spring and summer of 2011. All the parents chose to do the interviews in Spanish.

Measures

Adolescents' Depressive Symptoms. The Mood and Feelings Questionnaire (Angold, Costello, Pickles, Winder, & Silver, 1987) was used to assess the adolescents' depressive symptoms. The 33-item Likert-type scale measures the extent to which students experience depressive symptoms in the past two weeks. The measure included items such as "I didn't enjoy anything at all" and "I felt I was no good anymore," and students reported whether the statement was not true (0), sometimes true (1) or mostly true (2). This measure has demonstrated adequate psychometric properties (Daviss et al., 2006) and good reliability in this sample ($\alpha=.94$). The items were summed to compute to represent total depressive symptoms. The cut-off score for clinically significant depressive symptoms were scores above 27 (Daviss et al., 2006).

Maternal Depressive Symptoms. The 20-item Center for Epidemiologic Studies Depression Scale (CES-D) assessed current mothers' depressive symptoms. Respondents were given a list of feelings and behaviors and were asked to indicate how often they had

felt this way during the past month. Parents responded by rating from 0 to 3 (0= never, 1= once or twice, 2= several times, 3= almost every day). Sample items for this scale are “I was bothered by things that usually don’t bother me”, “I did not feel like eating; my appetite was poor.” Scores at or above 16 on the CES-D indicate clinically significant levels of depressive symptoms (Lyketsos et al., 1993). The CES-D has demonstrated adequate psychometric properties in a general population (Radloff, 1977). In our sample internal consistency of the scale was high (.87). The items were summed to compute to represent total maternal depressive symptoms.

Familism. The 18-item Attitudinal Familism Scale (Steidel & Contreras, 2003) was used to assess the adolescents’ beliefs and attitudes toward the family. The responses are on a 10-point Likert-type scale, ranging from *strongly disagree* (1) to *strongly agree* (10) and grouped into 4 subscales. The first subscale is *familial support*, which includes six items such as, “Aging parents should live with their relatives.” *Family interconnectedness*, a second subscale, is composed of five items. A sample item is, “A person should cherish time spent with his or her relatives.” A third scale, *family honor*, is made up of four items such as, “A person should feel ashamed if something he or she does dishonors the family name.” Fourth, *subjugation of self* for the family consists of three items. For example, “A person should be a good person for the sake of his or her family.” The internal consistency reliability for the overall scale was high in our sample ($\alpha=.90$). Validity of the scale was good as indicated by the correlations of familism factors with acculturation, generational status, and exposure to the United States (Steidel

& Contreras, 2003). The items were averaged to represent total adolescent reported familism.

Maternal Warmth and Support. Maternal warmth and support was assessed by measuring the adolescents' perception of these constructs using the Network of Relationships Inventory (NRI) (Furman & Buhrmester, 2009). The relationship features assessed are behavioral and observable in nature and are rated on a "how often" scale ranging from 1 (never or seldom) to 5 (always). The three parental affection items assessed warmth (e.g. "How much does this person really care about you?"). Examining stability over a one year period, comparison of different reporters, and observed interactions with mothers were used as validational evidence and all suggest adequate validity (Furman & Buhrmester, 2009). The Cronbach's alpha was .88 for the affection items in previous research with a diverse sample (Furman & Buhrmester, 2009). Cronbach's alpha was .91 for maternal warmth in our sample. An additional three items examined maternal support (e.g. "How often do you turn to this person for support with personal problems?"). Cronbach's coefficient for maternal support was .95 in a previous study with a diverse sample and was .98 in our sample (Furman & Buhrmester, 2009). The items were averaged to represent adolescent reported warmth and support.

Peer Support and Teacher Support. These 23 items were taken from the Child and Adolescent Social Support Scale (CASSS) Version 2 (designed for children from 6th to 12th grade) to measure adolescents' perceived social support from classmates and teachers (Malecki, Demaray, Elliott, & Nolten, 1999). Since the purpose of the study

was to examine peer relationships at school, only the relationships between peers at school or “classmates” were examined. Twelve of the items measured classmate support examining whether participants felt their classmates were nice, helpful, attentive, etc. An example item is, “My classmates tell me I did a good job when I’ve done something well.” Eleven items measured aspects of teacher support such as whether participants felt their teachers are helpful and treat them nicely and fairly. An example item is, “My teacher(s) spend time with me when I need help.” Adolescents respond by rating each item based on frequency of the events occurring. Frequency ratings consist a 6-point Likert scale from 1 (never) to 6 (always). Previous research with a diverse sample of students in the 6-12th grades indicates good psychometric properties (i.e. Cronbach’s alpha was .92 for teacher and .94 for classmates and adequate construct validity). Cronbach’s alpha was .99 in our sample (Malecki, & Demaray, 2002). These items were averaged to represent total adolescent reported peer and teacher support.

CHAPTER III

RESULTS

An examination of the means suggest these Latino adolescents reported high levels of familism ($M = 7.26$ out of 10), maternal warmth and support ($M = 4.00$ out of 5), and peer and teacher support ($M = 4.79$ out of 6). The total level of adolescent self-reported depressive symptoms on the MFQ was 9.60 and 21 adolescents (13.6%) reported clinically significant levels of depressive symptoms on the MFQ (i.e. scores above 27). Adolescent reported familism was associated with fewer adolescent depressive symptoms ($r = -.22$ $p <.01$). Means and correlations are presented in Table 1.

The mean level of maternal self-reported depressive symptoms was 10.59 with fourteen out of the 70 mothers (20.0%) reporting clinically significant levels of depressive symptoms on the CES-D (i.e. scores above 16). Adolescent reported maternal warmth and support was positively associated with adolescent reported familism ($r = .45$, $p <.001$). Surprisingly, adolescent reported maternal warmth and support was not significantly associated with maternal depressive symptoms. In addition, maternal depressive symptoms were not significantly related to adolescent reports of familism. Peer and teacher support was significantly positively related to familism as well as maternal warmth and support (see Table 1).

Preliminary analyses examining potential covariates revealed that age ($r = -.16, p < .01$) and gender ($t = 2.17 p < .05$) were related to familism so they were retained as covariates. Nativity status (foreign or native born) was not significantly related to any of the variables so it was not included in the analyses (t range = $-.12 - .14, n.s.$).

Consistent with past research on the moderating role of familism (Umaña-Taylor et al., 2011), a series of three-step hierarchical regression analyses were estimated to examine the main effects of familism, maternal depressive symptoms, maternal warmth and support, and peer and teacher support on adolescent depressive symptoms. After estimating the main effects, the interaction of each relational context with familism was entered in the model. All models controlled for age and gender. Per Aiken and West (1991), all predictor variables were centered and then product terms were created between familism and each predictor variable (i.e. maternal depressive symptoms, maternal warmth and support, and familism).

Familism and Depressive Symptoms

Controlling for age and gender, the main effects model with familism and adolescent depressive symptoms explained 5.4% of the variance and familism was significantly associated with fewer adolescent depressive symptoms ($\beta = -0.23, p < 0.01$).

Maternal Depressive Symptoms

The model with maternal depressive symptoms used the sample of the 70 mothers and their adolescent children. In the main effects model, familism was associated with

fewer adolescent depressive symptoms ($\beta = -0.31, p < 0.05$) and explained 9.9% of the variance. In the second step of the first regression, maternal depressive symptoms ($\beta = -.01, n.s.$) failed to be significantly related to adolescent depressive symptoms, but familism continued to be a significant predictor. At the third step, the introduction of the interaction terms with maternal depressive symptoms was insignificant ($\beta = .17, n.s.$) (See Table 2).

Maternal Warmth and Support

In the second step of the second regression model, maternal warmth and support was added to the model accounting for an additional 4.7% of the model. Maternal warmth and support was associated with fewer adolescent depressive symptoms ($\beta = -0.24, p < .01$), but familism was no longer significant. However, in the third step, the interaction term for maternal warmth and support was significant ($\beta = -.16, p < .05$, change in $F = 4.41$) and accounted for an additional 2.2% of the variance. This interaction effect was probed using the online calculation utility created by Preacher, Curran, and Bauer (2006). Simple slope values were calculated by treating maternal warmth and support as the moderator variable. The simple slopes one standard deviation above the mean of maternal warmth and support was significant ($b = -3.14, p < .001$) as well as the mean of maternal warmth and support ($b = -1.83, p < .05$). However, one standard deviation below the mean was not significant ($b = -0.52, n.s.$). See Figure 1 for a depiction of the interaction. At high levels of maternal support, familism was associated with fewest adolescent depressive symptoms.

Peer and Teacher Support

In a third hierarchical linear regression, at the second step, peer and teacher support was also associated with fewer adolescent depressive symptoms ($\beta = -0.26, p <.01$) and accounted for an additional 6.1% of the variance, and familism remained a significant predictor. The introduction of the interaction term with and peer and teacher support ($\beta = 0.15, p <.05$) was significant and accounted for an additional 2.2% of the variance (See Table 2). This interaction effect was probed using the online calculation utility created by Preacher, Curran, and Bauer (2006). Simple slope values were calculated by treating maternal warmth and support as the moderator variable. The simple slopes one standard deviation below the mean of peer and teacher support was significant ($b = -3.11, p < .01$) as well as the mean of peer and teacher support ($b = -1.60, p < .05$). However, one standard deviation above the mean was not significant ($b = -0.09, n.s.$). See Figure 2 for a depiction of the interaction. At low and mean levels of peer and teacher support, familism had a protective effect leading to fewer depressive symptoms. Whereas, at high levels of peer and teacher support, adolescents were already endorsing very low levels of depressive symptoms therefore familism did not have a significant additive effect.

Post Hoc Power Analyses

Post hoc power analyses revealed the regression with maternal depressive symptoms ($n = 70$) was underpowered. For the main effects model with 4 predictors and

an observed R^2 of .099, the observed statistical power was 0.52. For the moderation analysis, the observed power was 0.56 (Cohen, 1992).

CHAPTER IV

DISCUSSION

Latino youth are at a heightened risk for developing depressive symptoms compared to other ethnicities, yet how contextual factors interact with cultural values to influence the development of depressive symptoms has not been elucidated. The present study extends past previous research by exploring the relationship of familism to depressive symptoms in three novel relational contexts: maternal depressive symptoms, maternal warmth and support and peer and teacher support. Consistent with the majority of previous research, familism was protective against depressive symptoms (Smokowski & Bacallao, 2007; Smokowski et al., 2009; Smokowski et al., 2010; Ayón, Marsiglia, Bermudez-Parsai, 2010; Gonzalez et al., 2011). In addition, even in the contexts of maternal depressive symptoms, familism continued to be associated with fewer depressive symptoms. Furthermore, at low and moderate levels of peer and teacher support, familism had a protective effect leading to fewer depressive symptoms. Finally, familism failed to be protective when the adolescent did not perceive his or her mother to be warm and supportive or when adolescents endorsed high levels of teacher and peer support.

As hypothesized, maternal warmth and support moderated the relationship between familism and adolescent depressive symptoms such that in the context of a

highly supportive and warm mother, familism was associated with fewer depressive symptoms. However, the protective effects of familism were absent when adolescents reported low levels of warmth and support. A critical component of familism is the reciprocal nature of the family obligations and support. Each member of the family is expected to put the family's needs before their own and each functions on the assumption that other family members will likewise offer help when necessary (Steidel & Contreras, 2003). Without a foundation of maternal warmth and support, familism may no longer be viewed as reciprocated thus negating some of the protective effects. Moreover, having a mother who is not warm and supportive may violate the cultural assumptions associated with familism and therefore may be inconsistent with an adolescent's world-view. The adolescent may not view these sacrifices as fair in this context (Kuperminc, Jurkovic & Casey, 2009).

Contrarily, in the context of a warm and supportive mother-adolescent relationship, an adolescent would be more likely to view the sacrifices they make for their family in a positive way (e.g. making them feel important and needed). Sacrifices in this context may give the adolescent a sense of identity and purpose to support their family contributing to their decreased susceptibility to developing depressive symptoms (Fuligni, 1998). Maternal warmth and support may be a mechanism contributing to the protective nature of familism, but the results of this study suggest this is not the only

factor. Familism was related to increased warmth and support between family members, but the construct has many other important dimensions such as respect, obligation and family honor. The mechanisms responsible for the protective effect of familism are not well understood in adolescence, although the aspects of the parent-adolescent relationship have been implicated in previous research (Fuligni, Tseng & Lam, 1999; Smokowski & Bacallao, 2007).

While maternal warmth was protective, there was a multiplicative effect with familism. Thus, the mother-adolescent relationship may be an important component in the protective effects of familism, but this does not fully explain the relationship between familism and adolescent depressive symptoms. The adolescents with the fewest depressive symptoms were those with high values of familism in the context of a warm and supportive mother. This suggests the relationship between familism and adolescent depressive symptoms cannot be fully explained by maternal warmth and support. The familial cultural value of familism adds a unique protective effect over and above the associations with maternal warmth and support.

This study also suggests that in Latino families, maternal warmth and support may be more critical to adolescent's psychological well-being than maternal depressive symptoms. First, self-reported maternal depressive symptoms did not diminish the amount of perceived maternal warmth and support reported by the adolescent. Second, maternal depressive symptoms were not significantly related to adolescent depressive symptoms. Both of these results should be interpreted with caution, as the regression

with maternal depressive symptoms was underpowered. Nevertheless, although these findings contradict the majority of research with European American samples that has found a strong association between maternal depressive symptoms, parenting, and adolescent depressive symptoms (Hammen & Brennan, 2003; Marmorstein & Iacono, 2004), they are consistent with the few studies have been done with Latina immigrant mothers and their children (Corona et al., 2005; Ruttenberg et al., 1997). Moreover, there was no measure of functional impairment so even if mothers were experiencing depressive symptoms, these symptoms may not have been interfering with their social functioning (McKnight & Kashdan, 2009). Thus, it is possible that their level of symptomatology was not interfering with their ability to create a nurturing environment for their children as has been the case with previous samples of Latina mothers and their children (Corona et al., 2005; Ruttenberg et al., 1997). Likewise, Latinos, compared to European Americans, often express and present depressed mood in terms of somatic complaints and therefore these symptoms may interfere with interpersonal functioning less compared to symptoms such as emotional dysregulation or irritability (Escobar, Rubio-Stipe, Canino, & Karno, 1989; Corona et al., 2005).

Studies with European American adolescents show that individuals with mothers struggling with depression may be at an increased risk to develop depressive symptoms partially because of poor parenting (Hammen & Brennan, 2003; Marmorstein & Iacono, 2004). However, past research with Latina mothers with depression and their children have found no differences in mother's interactions with their children (Corona et al.,

2005; Ruttenberg et al., 1997). Perhaps, Latina mothers are better able to continue to give adequate parenting even when experiencing depressive symptoms. If this were the case, one of the mechanisms linking adolescent depressive symptoms to maternal depressive symptoms would be absent. This may have contributed to the absence of correlation between these constructs that are normally highly related in European American samples.

Along the same lines, cultural values may influence how maternal depressive symptoms affect parenting. Cultural prescriptions surrounding the role of the mother may influence mother's struggling with depressive symptoms to quietly suffer, but continue fulfill her parenting role (Falicov, 1998). For example, the cultural value of simpatía has been implicated in the literature to describe the cultural practice of maintaining harmony, creating warm and friendly relationships, and avoiding controversy and conflict (Comas-Díaz, 1989). In addition, the female gender-role construct of mariанизmo involves acting with humility, virtue, and decorum and emphasizes caregiving and stoicism (Gailamo-Ramos, Dittus, Jaccard, Johansson, Bouris, & Acosta, 2007).

The cultural values of simpatía and mariанизmo may lead a Latina mother struggling with depressive symptoms to purposefully hide her symptoms in order to continue to be an involved, warm and supportive mother. Indeed, in this sample, adolescent reported maternal warmth and support was not associated with maternal depressive symptoms suggesting mothers struggling with depressive symptoms were perceived as warm and supportive.

Also, supporting this notion, past research shows Latina mothers with depression did not act differently with their infants during a feeding scenario than Latina mothers not struggling with depression (Ruttenberg et al., 1997). Likewise, Corona et al. (2005) found that maternal depressive symptoms were not associated with adolescent reports of depressive symptoms, adolescent reported family satisfaction or outsiders' ratings of maternal behavior during a conflict conversation. Contrarily, maternal depressive symptoms were correlated with mother reports of family satisfaction and view of adolescent internalizing problems (Corona et al., 2005). Thus, although the mother may perceive disruption in the family, this disruption may not be visible to an outside rater or perceived by their adolescent child.

An additional cultural mechanism may be that Latino families are more accepting of psychopathology and work to accommodate it. The view of fatalism (i.e. viewing the future as inevitable or unalterable), a central construct to Latinos, in conjunction with marianismo may lead to Latina mothers to view their struggles as personal, inevitable obstacles to overcome (Cuéllar, Arnold & González, 1995). The adolescent may have been aware of the mother's psychological difficulties but was still able to feel supported by her even though she may have been failing to fulfill some of her duties as a mother. Perhaps, other family members such as an older sibling or cousin were helping with the family alleviating some of the increased stress due to the maternal depressive symptoms.

In sum, Latina mothers in our sample may have been successful at creating a nurturing environment for their adolescent children despite their depressive symptoms

due to cultural values such as familism, mariанизmo and simpatía leading them to place their needs secondary to the needs of the family (Corona et al., 2005; Ruttenberg et al., 1997). However, these results may not generalize to more severely depressed populations. Since this was a community sample, it is possible the quantity and severity of the maternal depressive symptoms of mothers in our sample may have not been interfering with their roles as a mothers or relationships with their adolescents. While a significant number of the mothers in our sample were clinically depressed (i.e. fourteen out of the 70 moms (20%), the majority of these mothers scored in the mildly depressed range (e.g. between 16 and 24) on the CES-D and only 4 of the mothers scored above 30. In addition, the small sample size may have underpowered these analyses. Future research examining the relationship between maternal depressive symptoms, familism and adolescent depressive symptoms with a larger sample of mother with clinical depression and their adolescents is critical for informing culturally sensitive therapies.

In addition to maternal warmth and support being a moderator, peer and teacher support also moderated the relationship between familism and adolescent depressive symptoms. It was predicted that peer and teacher support would strengthen the negative association between familism and depressive symptoms. However, the opposite occurred and peer and teacher support actually weakened the association. In the context of low peer and teacher support, familism had the strongest negative association with adolescent depressive symptoms. Thus, familism offset the risk of having negative school experiences. Familism was also related to fewer depressive symptoms in the context of

moderate levels of peer and teacher support. However, in the context of high peer and teacher support, familism was not related to adolescent depressive symptoms: adolescents in the context of high peer and teacher support reported the least depressive symptoms regardless of level of familism.

Adolescents in the context of low peer and teacher support and low familism were experiencing the most depressive symptoms suggesting they had the most to gain in terms of symptom relief from familism. It appears that these youth at the highest risk were isolated from both their school and cultural contexts. One explanation is that these youth may have difficulty forming close relationships in general and this may put them at risk for psychological distress. It is also possible these youth are having struggles within either their family environment or their school environment leading them to become more detached in general and exacerbating depressive symptoms. Finally, perhaps these are youth who are described as marginalized in the acculturation literature, are neither connected to US or Latino culture (Berry, 1997). Peer relationships may be particularly difficult for Latino adolescents given they must navigate the culture of their peer group and the culture of their families. Latino adolescents who are not able to successfully navigate these cultures and create a bicultural identity may have trouble fitting into either culture leading to depressive symptoms. Since this study is not longitudinal, it is also possible depressive symptoms are inhibiting these youth from forming positive relationships, and future work should examine this possibility. Given Latino adolescents with low peer and teacher support and low familism values are at the greatest risk for

developing depressive symptoms, it is important for prevention efforts to target this population.

In addition to an interactive effect, peer and teacher support and familism both have compensatory effects on adolescent depressive symptoms such that both peer and teacher support and familism each independently was related to fewer adolescent depressive symptoms. Moreover, peer and teacher support was also positively correlated with familism. In other words, an adolescent who values familism is more likely to have positive relationships with classmates and teachers. This is the first time to my knowledge that the relationship between peer and teacher support and familism has been directly examined. This is an important contribution to the literature because of the theoretical possibility of familism interfering with an adolescent's ability to form close relationships with their peers and teachers. Hypothetically, the increased amount of chores and family responsibilities associated with heightened familism could keep prevent adolescents from spending time with their peer group outside of school leading to feeling disconnected. This does not appear to be the case. Rather, respecting and promoting an adolescent's value of familism may be beneficial to school districts and teachers striving to keep that student feeling connected to his or her teachers and classmates. However, this study only examined support from peers at school (i.e. classmates). It is unknown how familism affects relationships of peers outside of school.

Taken together, these findings suggest interventions and preventions either helping to improve the family relationship or relationship with peers and teachers are

likely to be successful at decreasing Latino adolescent depressive symptoms. Familism may also interact with peer and teacher support to predict other academic outcomes (e.g. school motivation) or psychological outcomes (e.g. externalizing symptoms). Future research should examine if peer and teacher support moderates the relationship between familism and these academic outcomes.

Limitations

The sample had problems with restriction of range that may have influenced the results of the study. First of all, the sample was taken from an emerging Latino community in the Southeastern United States, therefore, most of the adolescents in the sample were either first or second generation. There was little variability in familism scores as the sample endorsed very high levels of familism as a whole ($M = 7.26$ out of 10). Future studies should examine these questions in a sample including greater variability in generational status and familism.

In addition, the study had a small sample of mothers which underpowered the regression with maternal depressive symptoms. Future research is needed to better understand the relationship between maternal depressive symptoms, the maternal-adolescent relationship, Latino cultural values and adolescent depressive symptoms. Given the high rates of depressive symptoms in Latino samples, it is imperative to further disentangle these relationships in both community and clinical samples.

Because the study was cross-sectional, directionality of effects was not established. Future research should examine the relationship between maternal

depressive symptoms, maternal warmth and support, peer and teacher support, familism and depressive symptoms longitudinally. In addition, future longitudinal research should examine whether high familism leads to greater peer and teacher support. More research is needed to better understand the contextual factors influencing familism as peer and teacher support as well as maternal warmth and support were salient contexts changing the relationship between familism and outcomes. Also, a better understanding in the mechanisms that make familism protective is needed.

The mean age of the sample was about 14 years old suggesting most of the sample was in the early adolescent stage. These individuals may only be beginning to assert their independence and may be more accepting of their parents' worldview than an older adolescent. Perhaps, if this study was replicated with older adolescents, the contextual influence may operate differently to affect the relationship between familism and depressive symptoms. A final limitation is that that most of the constructs (e.g. familism and maternal warmth and support) were adolescent report only, inhibiting comparisons between parent and adolescent reports.

Clinical Implications

Nonetheless, this study suggests familism is protective in most contexts in adolescence, but not all. Clinicians should be cognizant of the many contextual factors influencing a Latino adolescent's life before bolstering the value of familism. For example, an awareness of the multidimensional nature of familism may help clinicians in case conceptualizations. Clinicians may benefit from engaging adolescent clients in

conversations regarding familism and appropriately endorsing the components of the value that may be beneficial in each particular client's situation. This study suggests a greater understanding of how familism operates across contexts in adolescence is imperative for improving interventions. Also, adolescents in the contexts of low maternal warmth and support, low peer and teacher support, and low familism are at increased risk for developing depressive symptoms. These populations of youth should be targeted for preventative interventions. Bolstering the family, peer, and/or teacher relationship may be beneficial for such youth.

Conclusions

Overall, the results of this study suggest contextual factors influence the relationship between familism and adolescent depressive symptoms. Familism continued to be protective even in the context of maternal depressive symptoms, but was not protective in the context of maternal warmth and support. This suggests having a warm and supportive mother-adolescent relationship may be necessary to experience the protective effects of familism. The cultural proscriptions of simpatía and mariанизmo may influence a mother struggling with depressive symptoms to continue to be warm and supportive even in the face of psychological turmoil. This study also shows that familism confers protective effects over and above maternal warmth and support suggesting other mechanisms (e.g. respect, obligation, and family honor) contribute to the protective nature of familism not only the associations with maternal warmth and support. Finally, the results suggest peers and teachers are important for psychological

health in Latino adolescents as well as families. The adolescents at greatest risk for developing depressive symptoms are those with low peer and teacher support and low familism.

Professionals working with Latino families should consider the contextual factors that may influence the role familism plays. Also, future research should strive to better understand the contextual factors influencing familism and the mechanisms responsible for the protective effect of familism.

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APPENDIX A

TABLES AND FIGURES

Table 1. Correlations and descriptive statistics.

Variables	1	2	3	4	5
1. Adolescent Depressive Symptoms	--				
2. Maternal Depressive Symptoms	.04	--			
3. Familism	-.22	-.18	--		
4. Maternal Warmth and Support	-.28	-.13	.46	--	
5. Peer and Teacher Support	-.29	-.08	.28	.29	--
Mean	9.60	10.59	7.26	4.00	4.79
SD	10.40	9.57	1.52	.88	.86

Note. Correlations in bold are statistically significant at $p < 0.01$. Maternal depressive symptoms ($n = 70$).

Table 2. Linear regression model evaluating the relationship between familism and adolescent depressive symptoms controlling for age and gender.

	β
Age	.04
Gender	-.17*
Familism	-.23**
Model Summary	Adj. R ² = .054** F (3,176) = 4.46

Note: ***, $p < .001$, ** $p < .01$, * $p < .05$

Table 3. Hierarchical linear regression models evaluating maternal warmth and support, and peer and teacher support as moderators of the association between familism and adolescent depressive symptoms.

a. Maternal Warmth and Support as Moderator	Step 1 β	Step 2 β	Step 3 β
Age	.04	.05	.05
Gender	-.17*	-.20**	-.18*
Familism	-.23**	-.13	-.17*
Maternal Warmth and Support		-.23**	-.27**
Maternal Warmth and Support *Familism			-.17*
Model Summary	Adj. R ² = .054** F (3,176) = 4.46	Change in R ² = .042** F (4,175) = 5.65**	Change in R ² = .023* F (5,174) = 5.54**
b. Peer and Teacher Support as a Moderator			
Age	.04	.02	.03
Gender	-.17*	-.18*	-.20**
Familism	-.23**	-.17*	-.15*
Peer and Teacher Support		-.26**	-.27***
Peer and Teacher Support *Familism			.15*
Model Summary	Adj. R ² = .054** F (3,176) = 4.46	Change in R ² = .061 F(4,171) = 12.03	Change in R ² = .022* F(5,170) = 4.38*

Note: ***, $p < .001$, ** $p < .01$, * $p < .05$

Table 4. Maternal depressive symptoms as a moderator of the association between familism and adolescent depressive symptoms.

	Step 1 β	Step 2 β	Step 3 β
Age	-.06	-.06	-.06
Gender	-.14	-.14	-.14
Familism	-.31*	-.31*	-.30*
Maternal Depressive Symptoms		-.01	.05
Maternal Depressive Symptoms* Familism			.17
Model Summary	Adj. R^2 = .099 $F(3,64) =$ 2.35	Change in R^2 = .000 $F(4,63) = .01$	Change in R^2 = .002 $F(5, 62) = .172$

Note: * $p < .05$. $n = 70$.

Figure 1. Maternal warmth and support moderating the relationship between familism and adolescent depressive symptoms.

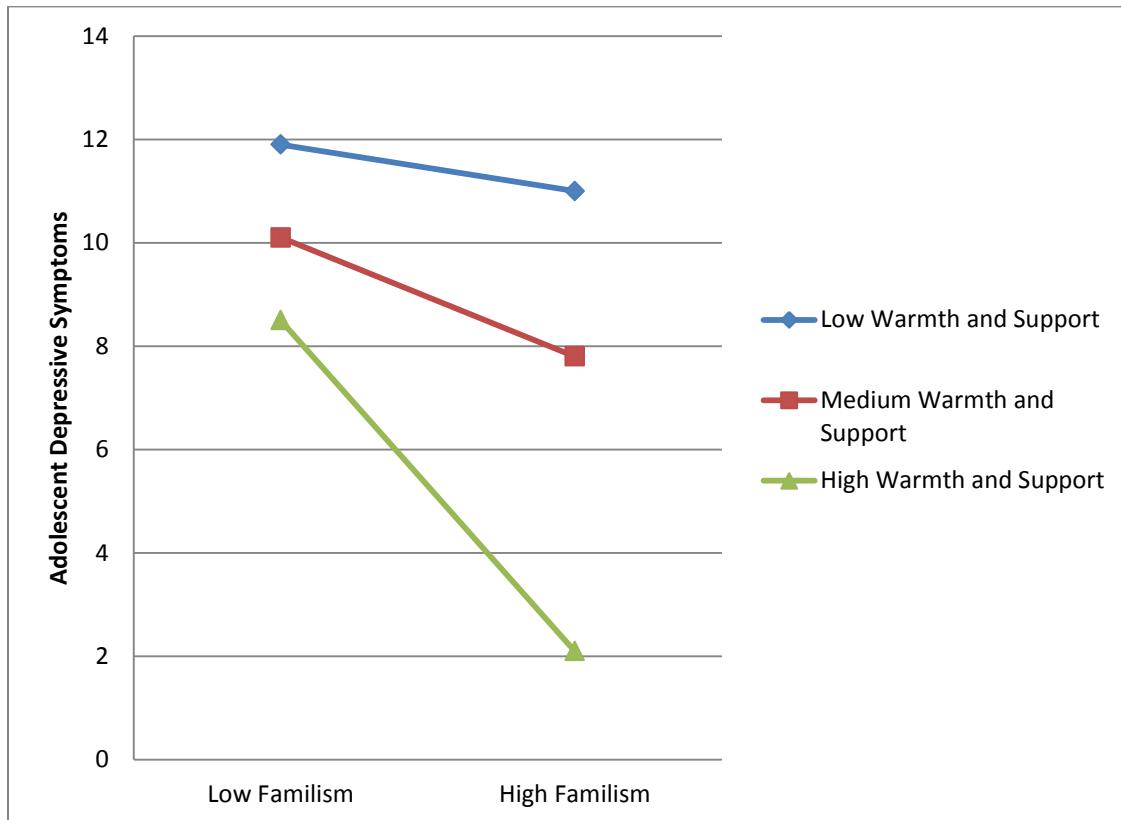


Figure 2. Peer and teacher support moderating the relationship between familism and adolescent depressive symptoms.

