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Examining Patient Satisfaction and Treatment Effectiveness for Hispanic Adolescents Receiving Intensive Mental Health Services for Depression

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by

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Abstract

Behavioral Activation (BA) is a treatment approach that has demonstrated promising outcomes for the adolescent population (Martin & Oliver, 2019). However, more studies are needed to examine its effectiveness with Hispanic adolescents. The prevalence and severity of depressive symptoms tend to be higher among Hispanic adolescents in comparison to their non-Hispanic White peers (Pratt & Brody, 2014). In addition, depressive symptoms are associated with poor social, academic, and later health outcomes (Naicker et al., 2013; Owens, Stevenson, Hadwin, 2012). Given the lack of prior investigations on the effectiveness of BA for Hispanic adolescents, this study aimed to fill a gap in the current literature by examining how Hispanic adolescents responded to BA treatment, as evidenced by changes in depressive symptoms and health-related quality of life. Hispanic adolescents in the study sought care at behavioral health clinics throughout the United States and were seen at multiple levels of care within intensive mental health care settings (i.e., intensive outpatient, partial hospitalization, and residential levels of care). In addition, providers underwent a 5-part allyship and belongingness training and targeted discussions to increase their knowledge of concepts such as privilege, bias, microaggressions. Therefore, the current study also assessed patient ratings of their satisfaction with care overall and as it related to provider sensitivity to their cultural identities. Lastly, this study aimed to examine the relationship between treatment outcomes and satisfaction with care overall, and the relationship between treatment outcomes and satisfaction with level of providers' cultural sensitivity.

The study found BA treatment significantly improved health-related quality of life and depressive symptoms for Hispanic adolescents. In addition, the study found that Hispanic adolescents ranged from "more satisfied than dissatisfied" to "very satisfied" with their care overall and as being sensitive to their cultural identity. When the relationship between treatment outcomes and satisfaction

with care overall was examined, researchers found satisfaction with care overall was not correlated with changes in depressive symptom severity or health-related quality of life. When the relationship between treatment outcomes and satisfaction with care as it relates to provider's level of cultural sensitivity was examined, researchers found satisfaction with care as it relates to provider's level of cultural sensitivity was negatively correlated with changes in health-related quality of life. It should be noted that clinic procedures included patients debriefing with a staff member if they had ratings on the Patient Satisfaction Survey below a 3. This procedure may have resulted in higher ratings on the Patient Satisfaction Survey for patients who did not want to engage in this debriefing. Future research should examine effectiveness in community health settings, utilize a standardized measure of satisfaction, and explore factors like acculturation to examine how they affect treatment outcomes or satisfaction with care.

Chapter 1: Introduction

Statement of the Problem

By 2050, there will be more Hispanic youth living in the United States, than non-Hispanic youth (Fry & Gonzalez, 2008). National surveys in the U.S. have shown that Latinx/e adolescents endorse higher levels of depression and suicidal ideation than African American or European American students (Wagstaff & Polo, 2012). About 1 in 4 high school students in the United States report having depressive symptoms that impact their daily functioning and while ethnic minoritized youth are more likely to report symptoms, they are less likely to receive mental health services (CDC, 2011; Merikangas et al., 2010).

Studies have shown that unique factors disproportionately impact minorized individuals and can increase the risk and chronicity of clinical depression. These include psychosocial stressors, racism/discrimination, acculturation, and economic stress (Watkins, Green, Rivers, & Rowell, 2007; Williams et al., 2007). Youth with depression are at greater risk for suicide and are more likely to take part in substance use, have low academic performance, and be perpetrators and victims of bullying in comparison to non-depressed peers (Bridge, Goldstein, & Brent, 2006; Diego, Field, & Sanders, 2003; Kovacs, Goldston, Obrosky & Bonar, 1997; Owens, Stevenson, Hadwin, 2012).

Prevalence rates of severe depression for Hispanic youth also tend to be higher than their non-Hispanic White peers according to national survey data collected from 2009 to 2012 (Pratt & Brody, 2014). Longitudinal studies have examined the health trajectories of youth with depression after 10 years and uncovered as adults they were more likely to report more physical health problems, physical inactivity, migraine headaches, and had higher smoking rates than non-depressed youth (Naicker et al., 2013). One study found clinically and subclinically depressed individuals had an increased risk for

mortality (Cuijpers & Smit, 2002). Further, researchers have found a 28-year loss in quality-adjusted life expectancy for depressed individuals, which is more years lost than heart disease, stroke, diabetes, hypertension, physical inactivity, and smoking (Jia et al., 2015). Pediatric onset of depression is linked to multiple poor outcomes and greater recurrence during adulthood (Gotlib & Hammen, 2008).

In the psychological treatment literature, cognitive-behavioral and interpersonal therapies have been most studied for treating depression (Zhou et al., 2015). However, according to a hallmark study comparing the efficacy of cognitive therapy to Behavioral Activation (BA), BA was found to be more effective in treating adult patients with severe depression (Dimijidan et al., 2006). Emerging literature on Behavioral Activation has demonstrated its effectiveness in adolescents and adults, but there continues to be a dearth in the literature surrounding its effectiveness for ethnically diverse youth (Martin & Oliver, 2019). Additionally, studies often include outpatient or school-based samples, but there is little research examining intensive levels of treatment (e.g., residential, partial hospitalization; Pina, Polo, & Huey, 2019).

Given the paucity of literature examining treatment satisfaction and outcomes for BA for Hispanic adolescents, the current study sought to examine how Hispanic adolescents responded to BA treatment, as evidenced by changes from admission to discharge in depressive symptoms and health-related quality of life. Providers underwent a 5-part allyship and belongingness training to increase their knowledge of concepts like privilege, bias, microaggressions, and completed cultural discussions with colleagues surrounding these concepts. The current study assessed satisfaction with intensive BA treatment. This included patient ratings of their overall satisfaction with care and as it related to provider sensitivity to their cultural identities. Lastly, this study aimed to examine the relationship between treatment outcomes and satisfaction with care overall, and the relationship between treatment outcomes and satisfaction with level of providers' cultural sensitivity.

This chapter will discuss the diagnostic markers of depression, trends in prevalence, and introduce the current literature surrounding help-seeking behaviors and treatment outcomes of Hispanic youth. Further, this chapter will provide an overview of the current study's theoretical framework and contributions to literature.

Diagnostic Markers for Depression

Major Depressive Disorder. In the DSM-V, Major Depressive Disorder (MDD) is classified as a disorder in which an individual experiences a loss of interest or pleasure and/or depressed or irritable mood (DSM-V-TR; American Psychiatric Association [APA], 2022). Additionally, the following symptoms are also described: decrease in energy or increased fatigue, insomnia or hypersomnia, lack of ability to think or concentrate, or recurrent thoughts of death. Individuals diagnosed with depression experience major depressive episodes, which are periods of depression that last more than two weeks. During this duration, individuals may experience depressive symptoms and can receive a diagnosis if they represent a change in prior functioning and are not attributed to another medical disorder (DSM-V-TR; American Psychiatric Association [APA], 2022). The DSM-V also notes that symptoms must cause clinically significant distress or impairment in functioning.

Suicide and Depression

Overall, there has been an increasing trend in suicide, with rates increasing by 30% in all age groups from 2000 to 2016 (Miron, et al., 2019). For adolescents (ages 15-24), the rate of suicide reached its highest since 2000 in 2017. Among those who have died by suicide, MDD was the most common diagnosis (about 30% of youth); when youth have comorbid affective and substance use disorders, this rate increases to about 54%. Overall, 90% of youth who die by suicide have at least one psychiatric diagnosis (Mullen, 2018). Studies have shown that individuals between ages 12 and 26 years old have an increased risk of death by suicide when diagnosed with a psychiatric disorder. Additionally, studies have found modest correlations between depression severity and suicide risk (Keilp et al., 2012). In depressed

individuals, studies have also shown that when subjective symptoms of depression improve suicidal ideation decreases significantly (Keilp et al., 2018). These subjective symptoms include sadness, loss of interest, low satisfaction, and tiredness (Keilp et al., 2018). Differences in trends also exist based on gender. Nationwide, more females have considered suicide than males, but more males have died by suicide (Mullen, 2018). Data has revealed an increase in the number of Hispanic adolescents in the U.S. who have died by suicide. In a 2015 survey, more Hispanic youth in grades 9-12 endorsed seriously considering suicide, making a suicide plan, and attempt in comparison to their non-Hispanic peers (Silva & Van Orden, 2018). Contrary to trends in suicide rates among all adolescents, Latinas tend to have higher rates of death by suicide (Silva & Van Orden, 2018).

Epidemiology of Depression

Studies have shown a sharp increase in the prevalence of depression from about 3% during childhood to 14% during adolescence (Cohen, et al., 1993). Additionally, findings suggest an increase in past- year prevalence of major depressive episodes. In 2005, about 9% of adolescents in the United States endorsed a major depressive episode in the past year, which increased to 11.3% in 2014 (Mojtabail, Olfson, & Han, 2016). Among Latinx/e adolescents ages 12-17, the reported 12-month prevalence of a major depressive episode was 23.9%. Studies have rendered that as Latinx/e youth become more acculturated, the prevalence of major depression increases when compared to youth who have newly immigrated to the United States.

Ethnic/Racial Differences in Prevalence. Early comparative studies investigating epidemiology of depression between ethnic groups found mixed findings. Saluja and colleagues (2004) found that 29% of Native American youths endorsed depressive symptoms. This compared to 22% of Hispanic, 18% of White, 17% of Asian American, and 15% of African American youths. Similarly, when Latinx/e youth were compared to Black and White adolescents, Kleykamp and Tienda (2005) found higher incidence of depression among Latinx/e adolescents. These findings held true even after adjusting for socioeconomic

status and familial structure. More recent reports have shown that Hispanic adolescents have significantly higher rates of depression when compared to their White, non-Hispanic counterparts (Substance Abuse and Mental Health Services Administration, 2015).

Gender Differences. Research has shown, during adolescent years sex differences also emerge with more females meeting criterion for MDD when compared to males as shown by cross-sectional and longitudinal studies (Hankin, Mermelstein, & Roesch, 2007; Wade, Cairney, & Pevalin, 2002). Studies have found differences in the symptom profiles of females; these include increased feelings of worthlessness, weight or appetite disturbances, guilt, and/or, suicidality in females as compared to males (Lewisohn & Essau, 2002; Lewisohn, Rohde, & Seeley, 1998; Smith et al., 2008; Yorbik, Bitmaher, Axelson, Williamson, & Ryan, 2004). Studies have illuminated females also experience more frequent depressive episodes and have an earlier age of onset for MDD (Smith et al., 2008). For adolescent girls, studies have found potential reasons that may explain the increased vulnerability for depression. Girls have been socialized to cope with life stressors in a passive, ruminative manner which is linked to depression (Hilt. McLaughlin, & Nolen-Hoeksema, 2010). Additionally, body dissatisfaction due to physical changes and early maturation can place adolescent girls at greater risk (Copeland et al., 2010; Stice, Hayward, Cameron, Killen, & Taylor, 2000). For transgender adolescents, there is also an increased risk for MDD. Studies have uncovered among transgender women, the lifetime prevalence of the disorder is about 62%, which may be due to lack of family support, social discrimination, and transphobia (Clements-Nolle, Marx, Guzman, & Katz, 2001; Oransky, Burke, & Steever, 2018).

Helping Seeking Behaviors and Mental Health Stigma

Stigma regarding mental health diagnosis has been shown to be a barrier for seeking services amongst minoritized communities (Collado et al., 2019). Among Latinx/e communities, there has been documented barriers in being able to access care and treatment retention once services have been initiated. Additionally, among Spanish-speakers, studies have shown lower utilization and greater

depressive symptom severity (Keyes et al., 2012; Sentell, Shumway, & Snowden, 2007). Studies examining help-seeking behaviors and mental health stigma among Latinx/e adolescents uncovered that only half of the youth surveyed believed therapy would be helpful, endorsed feeling as if attending therapy would be considered weird by family members, and feared being ostracized as a result. Within school-based clinics, Latinx/e students reported similar attitudes when asked about seeking mental health services these included: fears of embarrassment, feeling as if they should handle mental health problems on their own, concerns about confidentiality, and fear of judgement. In another study, Mendoza, Masuda, and Swartout (2015) found that among Latinx/e college students greater mental health stigma has been linked to less positive attitudes regarding help-seeking. While cultural attitudes have influenced help-seeking behaviors among Latinx/e youth, it is important to consider prior experiences of health care discrimination that may impact help-seeking. Prior investigations have shown patients who could recall instances of discrimination had more negative beliefs regarding healthcare systems and providers (Progovac et al., 2020). Additional studies in the Midwest examining attitudes among Latinx/e youth in the Midwest cited similar concerns regarding racism and cultural miscommunication of providers, which impacted mental health service utilization. The literature surrounding help-seeking behaviors, patient experiences while seeking mental health care, and mental health stigma show the need for more studies surrounding patient satisfaction and treatment outcomes among Latinx/e youth.

Treatment Outcomes Among Ethnic Minority Youth

While psychological treatments have been developed for a diverse group of psychological problems, prior to recent years little was known about the efficacy of treatments for ethnic/racial minoritized people (Huey & Polo, 2010). Some researchers have proposed the ethnic invariance perspective, which suggests that regardless of ethnic/racial identity, evidenced-based treatments are effective due to principles of therapeutic change being universal. Others have emphasized the ethnic

disparity view, which posits that psychological treatments have been developed for and by European Americans. Therefore, these treatments are not as effective for ethnic/racial minoritized groups (Huey & Polo, 2010).

Meta-analytic studies have evaluated studies on psychological treatments for ethnic minority adolescents from 1960 to 2018 (Pina, Polo, & Huey, 2019). Findings revealed most studies have focused on psychosocial treatments for mental health problems among Hispanic and Black/African American youth, with less literature surrounding Asian American and Native American adolescents (Pina, Polo, & Huey, 2019). Additionally, researchers found that 3 treatments (i.e., cognitive behavioral treatment, multisystemic therapy, family-based therapy) were found to be well-established for youth mental health problems (i.e., anxiety, behavioral problems, substance use). However, none of the well-established interventions were for pediatric depression. Interpersonal therapy was the only treatment classified as a probably efficacious treatment for depression in Hispanic youth, meaning more than one study showed that it was effective and had adequate representation of Latinx/e youth. In the Pina, Polo, & Huey (2019) review of treatments for depression, BA had not yet been reviewed as treatment for culturally diverse adolescents, showing the need for further examination of its effectiveness for Hispanic youth.

Behavioral Activation

BA is a treatment based on the premise that depressed people tend to access less positive reinforcement from their environments and engage in less positive activities. As part of the intervention, individuals learn the connection between their activities and their mood states; additionally, people plan a schedule of activities to bring about more positive reinforcement (Lewisohn, Biglan, & Zeiss, 1976). Research has shown activity scheduling is an effective psychological treatment for adults with effect sizes as large as 0.87 (Ekers et al., 2014; Lipsey & Wilson, 1993). Further, additional studies have found that adding cognitive techniques to BA do not improve treatment outcomes immediately following the intervention or at a two-year follow-up, and for severe depression, BA performed better than traditional

cognitive therapy (Dimijian et al., 2006; Gortner et al., 1998). For adolescents, the intervention has shown promise in that several randomized controlled trials have found BA to be an effective treatment for adolescents with large effect sizes (Martin & Oliver, 2019). Additionally, another small pilot study found BA to be an effective treatment for adolescents when used as a brief 7-week treatment.

Quality of Life

Generally, quality of life has been given different definitions in the literature. For example, the World Health Organization has developed a definition for quality of life, in which it is described as a person's subjective view of their position in life, in the context of their culture and values. Other researchers have thought of quality of life as levels of enjoyment and satisfaction people experience (Mendlowicz & Stein, 2000). Mental health problems are often associated with lower levels of quality of life, due to decreased control, autonomy, self-esteem and negative impacts on relationships (Connell, Brazier, O' Carhain, Lloyd-Jones, & Paisley, 2012; DSM-V-TR; American Psychiatric Association [APA], 2022). Literature examining depressed adults has found that greater severity of depressive symptoms tends to decrease quality of life. For Hispanic adults, the study also uncovered that being Hispanic was also associated with lower health-related quality of life (Connell et al., 2012). However, extensive research has shown youth without psychological problems do not always endorse having a high quality of life. On the other hand, not all youth who experience psychological problems endorse low quality of life (Bastiaansen, Koot, & Ferdinand, 2005; Cowen, 1994).

The Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire (PQ-LES-Q) is an assessment of the degree to which an individual experiences satisfaction and enjoyment in multiple domains of life (Endicott, Nee, Yang, & Wohlberg, 2006). Past studies have validated the use of the PQ-LES-Q with youth receiving outpatient treatment for depression (Endicott, Nee, Yang, & Wohlberg, 2006). However, the few studies evaluating ethnically diverse youth have focused on improved symptomology without examining improvements in quality of life (Gunlicks-Stoessel &

Mufson, 2011; Ngo et al., 2009, Tompson, Sugar, Langer, & Asarnow, 2017). The current study utilized the PQ-LES-Q and sought to examine both changes in symptomology and quality of life pre- and post- BA treatment.

Symptom Severity

Symptoms of depression can range from subclinical levels, to mild, moderate, or severe (Beck et al., 2011). Studies have shown mixed findings in that depressive symptom severity may predict suicidal ideation, persistence of depression, and functional impairment (Lopez et al., 2020; Zimmerman, 2018). Additionally, the DSM-V criterion tend to be moderately correlated with depressive symptom severity. In other words, as symptoms like depressed mood, sleeping problems, changes in psychomotor functioning, and suicidal ideation increase, depression severity tends to increase (Zimmerman, 2018). In the current study, the Quick Inventory of Depressive Symptomology (QIDS) was used, and it measures DSM-IV symptoms for MDD, with ratings from least to most severe. In the psychological treatment literature, symptom severity has been the primary outcome of studies examining treatment efficacy (Krause, Bear, Edbrooke-Childs, & Wolpert, 2019). In clinical practice, levels of severity can affect the type of treatment used, the level of care (e.g., partial hospitalization, residential), and can impact decision-making regarding an individual's disability status.

Treatment Satisfaction for Ethnic Minoritized Youth

The current study focused on satisfaction with care at intensive mental health care settings. Prior studies have defined satisfaction with care as encompassing six broad domains which included sense of normality, safety, comfort in living environment, feeling cared for and supported, participation in decision-making, and sense of improved wellbeing (Southwell & Fraser, 2010). Other studies have found treatment satisfaction to be associated with positive adolescent and staff relationships in residential care (Harder, Knorth, & Kalverboer, 2012).

The current study also examined patient satisfaction with providers' level of cultural sensitivity. Prior studies, examining the cultural sensitivity of providers have found that when clients perceive providers display sensitivity towards an individuals' cultural beliefs, it is associated with improvement in therapeutic outcomes (Hook et al., 2013; Owen et al., 2013). Additionally, cultural sensitivity is also salient in that studies evaluating the treatment disparities in ethnic/racial minoritized groups point to past experiences that further distrust and contributes to preferences for informal methods of support when faced with mental health challenges. Thus, the current study sought to examine the relationship between satisfaction with perceived cultural sensitivity of providers and treatment outcomes.

Theoretical Framework

The developmental psychopathology model focuses on understanding various psychobiological and environmental pathways that can contribute to the development of psychopathology. This model posits that psychobiological vulnerabilities interact with environmental variables, which can lead to deviations in healthy development. Within the developmental psychopathology model, this relationship is reciprocal and bidirectional. For example, in children, environmental stressors can also interact with psychobiological vulnerabilities (Eme, 2017). Psychological problems are then diagnosed when behaviors deviate from healthy development and impair or lead to maladaptive functioning. In determining maladaptive or adaptive functioning, culture guides clinical judgement on the normality of behaviors as behaviors may be viewed differently depending on a child's cultural context. Culture can determine the environmental settings a child is exposed to, and inappropriate socialization can also increase environmental stress (Chen, Fu, & Ling, 2014). The current study employed the developmental psychopathology model as Latinx/e adolescents experience unique environmental stressors that may impact the severity of depressive symptoms, as well as their overall quality of life (Williams et al., 2007). Adolescents with maladaptive coping behaviors may contribute to their environmental stressors that may lead to the development and exacerbation of depressive symptoms (Ryder et al., 2012).

The second theoretical approach which guided the current study was the Behavioral Theory of Depression (Lewinsohn, 1974). This theory suggests depressive symptoms occur due to an individual receiving reinforcement for depressed behaviors (e.g. avoidance) and reduced reward for healthy behaviors. In this model, behavioral avoidance leads to less chance of positively reinforced behaviors, which also continue the depressed cycle. Behavioral Activation was developed to increase access to positive reinforcement from the environment by an individual engaging in pleasant, routine, and valued activities (Lewisohn, Biglan, & Zeiss, 1976). Typically, the selection of these activities is led by the client to ensure scheduled activities take an individual's context into account, while also providing positive reinforcement. BA also targets avoidance as individuals are directed to practice alternative coping strategies rather than avoidance (e.g., skipping school, ignoring phone calls). In this study, the Behavioral Theory of Depression guided the treatment approach (BA) for Latinx/e youth who underwent treatment for depression.

Research Questions

The current study sought to examine the efficacy and treatment satisfaction with BA among Hispanic adolescents. An analysis of patient quality of life, symptom severity, and satisfaction following treatment occurred to answer the following questions:

1) How did Hispanic adolescents respond to Behavioral Activation (BA) treatment, as evidenced by changes from admission to discharge in depressive symptoms and health-related quality of life?
2) How satisfied were Hispanic adolescents with intensive BA treatment, both overall and as being sensitive to their cultural identity?
3) What is the relationship between treatment outcomes and satisfaction with care overall?
4) What is the relationship between treatment outcomes and satisfaction with providers' levels of cultural sensitivity?

Contributions to the Literature

Interventions for depression have typically used outcome measures to assess changes in symptomology before and after treatment (Krause, Bear, Edbrooke-Childs, & Wolpert, 2019). For BA in particular, previous studies examining its effectiveness for adolescents have also focused on solely symptomology (Martin & Oliver, 2019). The current study aimed to contribute to extant literature by focusing on both positive and negative indicators of mental health (i.e., quality of life, depressive symptom severity). This study also incorporated treatment satisfaction with care overall and as it relates to cultural sensitivity. Regarding satisfaction with care among youth who have undergone depression treatment, one pilot study examined treatment satisfaction with of brief BA treatment, with most adolescents in the study reporting liking BA treatment overall and qualitative feedback included youth enjoying the activity scheduling and considering their own values (Pass, Lejuez, & Reynolds, 2018). However, prior literature has not examined this outcome amongst minoritized youth, despite reports on ethnic minoritized clients being more likely to report dissatisfaction with the quality of mental health care (Meyer & Zane, 2013).

Definition of Key Terms

Adolescents. Stage of development characterized by persons being between ages 11-21 years. This stage has been grouped into the following ranges: late adolescence (18-21), middle adolescence (15-17), and early adolescence (11-14; Arpawong, Oland, Milam, Ruccione, & Meeske, 2013; Futures & American Academy of Pediatrics, 2008; Hardin, Hackell, & Committee on Practice and Ambulatory Medicine, 2017).

Culture. Unique or distinct customs, values, language, beliefs, and behaviors of a particular group within society (American Psychological Association [APA], 2015). These groups can include a profession, social class, age group, ethnicity, or race.

Cultural Sensitivity. Appreciation, awareness, and humility regarding the beliefs, values, and norms of a culture that may not be one's own, as well as a willingness to adapt one's behavior accordingly (American Psychological Association [APA], 2015).

Depression/Depressive Symptoms. These terms are used to describe symptoms in the DSM-V, which outline the mood, cognitive, and somatic changes that occur when one has a depressive disorder and impacts their ability to perform daily activities (DSM-V; American Psychiatric Association, 2022).

Ethnicity. This term is used to describe groups of people who share the same descent and belong to a cultural or national group. Ethnicity is not biological, but represents social markers in society (Quintana et al., 2006).

Intensive Mental Health Care Settings. Those with higher levels of care where patients spend a longer duration in treatment compared to traditional outpatient therapy. These can include intensive outpatient, partial hospitalization, residential, or inpatient levels of care.

Latinx/e. Latinx and Latine are gender neutral forms of the word, Latino. Latine uses an "e" rather than a "x," because it is easier to pronounce for Spanish-speakers. The letter "e" is also used gender neutrally at the end of words like *estudiante* in Spanish (Gonzales, 2021).

Mental Health Stigma. Negative social evaluation that is internalized by those who have been diagnosed with a mental health condition and can be a deterrent for seeking treatment (Interian et al., 2007)

Treatment Outcomes. In this study, the measurement of symptomology and quality of life following an intervention (Kwan & Rickwood, 2015).

Chapter 2: Literature Review

The purpose this chapter is to examine the extant literature related to treatment outcomes and treatment satisfaction among Hispanic adolescents. This chapter begins with an introduction to adolescent depression, risk factors pertinent to the disorder, and risk factors related to depressive symptoms. The chapter then details the impact of depression on quality of life, treatment outcomes related to the disorder, and prior literature on treatment satisfaction related to minoritized youth. Finally, this chapter focuses on patient satisfaction with psychological interventions, specifically ethnically diverse adolescents.

Adolescent Depression

Overview. Depression is one of the most common psychiatric disorders and has adverse effects on adolescent functioning in multiple domains. Adolescent depression has been associated with increased school dropout, unwanted pregnancy, lower odds of entering postsecondary education, substance abuse, and intimate partner violence (Clayborne et al., 2019). Additionally, onset of a depressive disorder during adolescence has been linked to more chronic and severe depressive episodes 5 years later (Hammen et al., 2008). This chapter first introduces the mechanisms that may contribute to the development of depression, provides an overview of approaches to treat the disorder, and finally discusses a review of the factors that influence treatment acceptability and treatment outcomes.

Etiology. Increased vulnerability to depression has been linked to several biological, psychological, and social factors that interact with environmental vulnerabilities. Research has shown

that early childhood adverse experiences, interpersonal conflict, and social isolation increase the risk of depression and can affect many systems in one's body, including the neuroendocrine and immune systems. Individual characteristics include a child's temperament and genetic traits, which explain why different children may be affected differently by environmental stressors (Eme, 2017). This interaction has been described in the developmental psychopathology model which emphasizes interactions between individual traits and the environment can increase risk for psychopathology (Beauchaine & Hinshaw, 2017).

Genetic Vulnerabilities. Prior studies have shown that several genes contribute to an increased risk of developing depression and future research still seeks to uncover how multiple genes interact with the environment and influence risk. Twin studies have suggested that genetic factors contribute to risk, with studies showing moderate heritability (Shadrina et al., 2018). Stress has also been identified as a strong predictor for developing depression and the HPA axis is a key response system that controls the production of cortisol, the stress hormone. Studies have shown that depressed patients have elevated cortisol levels and increased activation of the HPA axis (Shadrina et al., 2018). Additionally, low levels of neurotransmitters, including norepinephrine and serotonin have been linked to the development of depressive disorders (Pennington, 2002; Shadrina et al., 2018). Other studies have examined the role of circadian rhythm genes and have found disturbances with the circadian rhythm in the brain are also a risk factor for depression development. Given the current state of the literature surrounding the genetic basis of depressive disorders, multiple genetic factors and dysfunction within several bodily systems, it is clear genetic and biological factors play a role in risk factors related to the disorder.

Cognitive Processes

The cognitive processes of depressed individuals have generally been described as having a negative self-perception, views of the world, and future (Beck, 1967). Among Latinx/e college students,

one study demonstrated that students who reported negative automatic thoughts about themselves had increased depressive symptomology (Calvette & Connor-Smith, 2005). According to Beck's cognitive model (1967), these thought patterns lead to feeling depressed emotionally and lead to individuals engaging in maladaptive behaviors (e.g., isolation). These negative cognitive processes become automatic and with time depressed individuals develop maladaptive schemas. Schemas then lead to incorrect or distorted interpretations of life events. Consistent with Beck's theory, studies have demonstrated abnormal thinking patterns in depressed individuals, including memory and attentional biases, dysfunctional attitudes, and rumination (Alloy et al., 2001; Gibb, 2014). In clinical care, these habitual thinking patterns are often identified as thinking errors or cognitive distortions. For example, a common thinking error depressed individuals report experiencing is overgeneralization in which a person believes one negative event is part of a continuing cycle of negative events that may never end (Southam-Gerow, 2011). Other theories have also illuminated the cognitive processes of depressed individuals, including Hopelessness Theory coined by Abramson, Metalsky, and Alloy (1989). Hopelessness Theory is a vulnerability-stress model that emphasizes low self-efficacy following the occurrence of negative life events. Within this model, depressed individuals have more negative predictions about the future and feel less able to handle future negative events, which illuminates more maladaptive thinking patterns related to this disorder. Overall, the literature supports the relationship between negative cognitive processes and increased risk for the development of a depressive disorder.

Familial Factors

Several studies have shown that children of depressed parents are more likely to be diagnosed with depression, substance use, and anxiety disorders (Klein et al., 2001; Klein, Lewinsohn, Seeley, Rohde, & Olino, 2005; Kovacs, Goldston, Obrosky, & Bonar, 1997; Weissman et al., 2006). Evaluations have been conducted to examine family factors that increase depression risk and have uncovered high

levels of criticism, rejection, parental conflict, and inconsistency have been linked to more cognitive distortions in adolescents (Bruce et. al., 2006; Liu, 2003). Another study examined how maternal emotional expression predicts onset of depressive symptoms during adolescence. This study found more cruel, argumentative, or self-critical verbal statements from parents rather than approving or validating statements predicted MDD onset in their children (Schwartz et al., 2014). Other studies have linked genetic and environmental interactions as it relates to parenting styles. One study found that adolescent boys with a short 5HTTLPR allele who reported low levels of family support were more likely to have increased depressive symptoms when compared to boys without the short 5HTTLPR allele (Li, Berk, & Lee, 2013). Having a short 5HTTLPR allele has been linked to greater perceived stress and increased risk for depression, showing how familial factors can interact with pre-existing biological vulnerabilities. In community and clinical samples, higher levels of parental criticism, maltreatment, and intrusiveness have been reported by depressed youth compared to nondepressed peers (Gibb, 2014; McLeod, Weisz, & Wood, 2007; Yap & Jorm, 2015).

Interpersonal Relationships

Depression affects several domains of adolescent functioning including interpersonal relationships and research has demonstrated that social difficulties are bidirectional in that depressive symptoms increase interpersonal challenges as interpersonal challenges give rise to depressive symptoms (Witvliet, Brendgen, Van Lier, Koot, & Vitaro, 2010). Amongst minoritized populations in the United States, researchers have also found an association between depressive symptoms and a lack of stable and supportive relationships (Whitbeck et al., 2010). The Interpersonal Theory of Depression was developed by Coyne (1976) and noted that the behaviors of depressed individuals can lead to negative responses from other people. As depressed people experience difficulties socially, they have more difficulties maintaining relationships which can lead to more negative social-cognitive processes.

Research shows that depressed people engage in more negative feedback seeking as well as more reassurance seeking in relationships and are more likely to have negative perceptions about their social skills (Evraire & Dozois, 2011; Lee et al., 2010). These negative perceptions have included self-reports of more rejection from peers, greater victimization, and poorer peer relationships when compared to nondepressed youth (Lau, Belli, Gregory, & Eley, 2014). Evraire & Dozois (2011) found that negative feedback seeking and excessive reassurance seeking may be associated with more frequent rejection from peers. Researchers theorize that since both peer and romantic relationships become more important during adolescence, social challenges may pose an increased risk for depressed mood in this age group (Rudolph & Flynn, 2014).

Life Stress

The Diathesis-Stress Model, also referred to as the stress-vulnerability model, highlights the interaction of genetic predisposition and environmental stress which can facilitate the development of psychopathology (Colodro-Conde et al., 2018). Research has shown stressful life events are associated with depression onset and recent studies have examined the specific types of life events that predict onset (Grant et al., 2014; LeMoult et al., 2020). An analysis of studies between the years 1990 and 2018 on the relationship between early life stress and MDD uncovered early life stressful events are associated with an increased risk for MDD onset before age 18 (LeMoult et al., 2020). Additionally, certain stressful events were not associated with an increased risk. These included experiencing poverty, a natural disaster, an illness, or physical injury. In contrast, the meta-analysis revealed those who experienced physical abuse, sexual abuse, death of a family member, or emotional abuse were significantly more likely to become depressed during adolescent years (LeMoult et al., 2020).

The COVID-19 pandemic resulted in significant stress for students with school closures and social isolation. Studies have examined the impact of COVID-19-related stress on students and found

across all grade levels at least 40% of students endorsed depressive symptoms that fell in the significant range on a depression inventory scale during remote learning (Demaray et al., 2022). Studies with Hispanic participants have found youth who reported traumatic events while immigrating into the United States and instances of discrimination were at an increased risk for depressive symptoms (Arellano et al., 2019; Paradies et al., 2015). Stressful life events can potentially alter brain structure, processing, and gene expression (Lohoff, 2010). In fact, research has shown that even in utero exposure to stress is associated with development of depression during adolescence in offspring (Kingsbury et al., 2016). In sum, adolescents may have a genetic vulnerability to a disorder, but depression onset may not occur until significant or cumulative environmental stress happens.

Impact on Quality of Life

Depressive symptoms impact several aspects of adolescent functioning, which can lead to reduced quality of life. These impacts may be witnessed at school, at home by caregivers, or during extracurricular activities. The following section is a review of how depressive symptoms affect various areas of life for adolescents.

Academic. Studies have found associations between depressive symptoms and decreased educational achievement (Hishinuma et al. 2006; Lepore et al., 2013; Repetto, Caldwell, Zimmerman, 2004). More specifically, among a group of Native Hawaiian adolescents results from a study indicated that higher depressive symptoms were associated with lower grade point averages for high schoolers ((Hishinuma, Chang, McArdle, & Hamagami, 2012). In addition, to poor academic performance, depressed students tend to have greater drop-out rates when compared to non-depressed peers and this was found to be mediated by negative perceptions about one's academic ability (Fletcher, 2009; Quiroga, Janosz, Bisset, and Morin, 2013). A study examining low-income Latinx/e adolescents found having depressive symptoms were also correlated with lower report card grades and lower scores on

standardized tests. Researchers found this was mediated by work avoidance and self-efficacy. Longer term, researchers have found early onset of a depressive disorder has been correlated with decreased post-secondary educational attainment and future income earnings (Berndt et al., 2000; Wickersham et al., 2021).

Social. Compromised social relationships are a predictor for depression onset and can exacerbate pre-existing symptoms. Social anhedonia is another aspect of depressive symptomology, where an individual feels less pleasure from social interactions and interpersonal relationships (Atherton, Nevels, Moore, 2015; Germine, Garrido, Bruce, Hooker, 2011). Studies have shown even after symptoms improve, social difficulties persist for at least three years after or up to 10 years (Naicker et al., 2013; Rhebergen et al., 2010). For depressed adolescents, studies have predicted lower perceived levels of social support once they enter adulthood (Naicker et al., 2013). Among Hispanic youth, research has shown a significant relationship between perceived social status and later depressive symptoms for adolescents who immigrated into the United States (Jaggers & MacNeil, 2015).

Social media use has become a popular way adolescents connect with peers and researchers have begun to evaluate its association with internalizing disorders. A newer study revealed spending just 30 minutes on social media was correlated with greater internalizing problems. This was hypothesized to be facilitated by adolescents experiencing more sleeping problems with more frequent phone use, experiences of cyberbullying, and the increased tendency for teens to compare themselves to images seen online (Riehm et al. 2019). This finding has also been replicated among Hispanic teenage girls with higher screen-use associated with greater internalizing symptoms (Perrino et al., 2019).

Emotional. Emotion regulation difficulties and sustained negative affect are two traits associated with depressive symptoms. For Hispanic adolescents transitioning into adulthood, one study revealed using greater emotion regulation strategies moderated the relationship between resilience and

depressive symptomology (Cano et al., 2020). In contrast, Durbin and Shafir (2008) found depressed individuals tend to regulate their emotions through rumination, which increases focus on negative events or one's depressed mood. Additionally, depressed individuals may suppress their negative emotions, which limits the development of coping skills (Durbin & Shafir, 2008). Vanderlinda et al. (2020) summarized emotional states of depressed people which involved frequent down regulation of positive emotions. Researchers have also found depressed individuals are less exposed to situations that elicit positive emotions and are less likely to use strategies to upregulate positive emotions like savoring (Vanderlinda et al., 2020)

Behavioral. Researchers have elucidated behavioral factors that contribute to and maintain depressive symptoms. Studies have found more emotional and behavioral avoidance in chronically depressed patients (Brockmeyer et al., 2015; Köhler et al., 2019). Studies have also revealed a bidirectional relationship between health-risk behaviors and increased risk for developing a depressive disorder and linking adolescent depression to later health-risk behaviors (HRBs; Bai et al., 2018; Naicker et al., 2013). These HRBs have included alcohol abuse, substance use, engaging in unprotected sex, and smoking. Bai et al., 2018 found that health-risk behaviors also increased chances of youth endorsing depressive symptoms at 6 month follow up. Another study found depressed teens endorsed a higher rate of smoking at baseline and smoking predicted depressive symptoms (Naicker et al., 2013). Additionally, severe depressive symptoms have been found to predict obesity (Bai et al., 2018).

Summary

Causes of depression have been researched extensively with evidence pointing to a variety of factors like environmental stressors, biological susceptibility, and personal characteristics contributing to its development. The literature suggests depression frequently occurs when there is an overlap of stressors along with low perceived levels of social support paired with maladaptive coping strategies. In

terms of predictors and correlates, newer studies suggest depressed people tend to engage in more social media use, have trouble engaging with others socially, and report higher rates of health-risk behaviors.

Overview of Treatment Approaches

Psychological treatments for depression commonly found in the literature are largely interpersonal, cognitive, or behavioral. Cognitive behavioral therapy (CBT) has been the most studied but is considered equally as effective as other therapies for depressed youth (Krause et al., 2019). Interventions for depression have rendered positive findings for youth outcomes including significant improvements in depressive symptoms, self-esteem, family communication, and quality of life. The following section provides an overview of the literature for psychological treatments for depression as well as a review of treatment methods for Hispanic youth.

Cognitive Behavioral Therapy. The most studied psychosocial treatment for depression in both adolescent and adult populations has been Cognitive Behavioral Therapy or CBT. Due to CBT's demonstrated effectiveness in the literature, it has been considered a well-established treatment (Cuijpers et al., 2013). CBT approaches generally involve psychoeducation, emotion identification, problem-solving, and self-monitoring. As part of CBT clients learn cognitive restructuring which involves identification and challenging unrealistic or unhelpful thoughts (Huberty, 2011). In studies of adolescents and adults, there has been no difference in improvements between CBT and other evidence-based approaches. For treatment of pediatric depression, CBT was more effective when parents or caregivers were involved in therapy, when behavioral activation was utilized, or cognitive restructuring was incorporated (Oud et al., 2019). However, a review of studies revealed small effect sizes were found at follow-ups which ranged from 17 to 31 weeks following treatment, which may be due to the high rates of recurrence in depression (Oud et al., 2019). In addition to Interpersonal Therapy

(IPT), CBT was the only other therapeutic intervention for pediatric depression that rendered significant treatment outcomes when compared to most waitlist and treatment as usual (TAU) conditions (Zhou et al., 2015).

Interpersonal Therapy. Interpersonal therapy (IPT) is another well-studied psychological intervention that has similar effects in reducing depressive symptoms as other treatments (i.e., CBT). The focus of IPT is to improve functioning in interpersonal relationships as depression occurs in an interpersonal context and impairs social relationships; trouble with interpersonal relationships then leads to increased and maintained depressive symptoms, which IPT primarily targets through intervention (Huberty, 2012). IPT is multiphasic and includes psychoeducation, an analysis of areas in which one experiences interpersonal problems, and practice implementing communication and problem-solving skills. When combined with medication, researchers have found that people have lower rates of relapse following IPT (Cuijpers et al., 2011). IPT has been adapted for the pediatric population and studies have demonstrated that it is an effective treatment for improving symptoms and overall functioning in comparison to TAU (Mufson et al., 2004). Additionally, with adolescent populations IPT has been found to have large effect sizes when delivered in different modalities (i.e., individual or group therapy; Mychailyszyn & Elson, 2018).

Behavioral Activation. Behavioral Activation (BA) was founded on the behavioral theory of depression which hypothesized that depressed people receive less positive reinforcement from their environments. BA was originally thought to be a second-line treatment for adults with treatment-resistant depression or adults who did not experience improvement with CBT (Jacobson, Martell, & Dimidijan, 2001). During BA treatment, clinicians create a functional analysis to determine behaviors that maintain depressive symptoms and the depressed individual is then provided with psychoeducation around avoidance behaviors that contribute to symptoms (Huberty, 2011). Then, depressed individuals

are taught to engage in routine, pleasant and valued activities to alter the depressed person's avoidant behaviors. Following a review of 34 randomized controlled trials, studies found that BA was more effective than control conditions and there was no difference in efficacy in comparison to CBT approaches (Mazzucchelli et al., 2009). Additionally, studies of BA for adolescents have found statistically significant improvements in depressive symptoms, global functioning, and quality of life. However, more studies are needed with diverse populations of adolescents to determine generalizability (Martin & Oliver, 2019; McCauley et al., 2016).

Pharmacotherapy. For children and adolescents, the U.S. Food and Drug Administration (FDA) has only approved fluoxetine (Prozac) and escitalopram (Lexapro) for use for pediatric depression (Selph & McDonagh, 2019). When prescribed to youth, prescribers must routinely assess for thoughts of suicide and suicidal behaviors as these have increased in clinical trials of youth taking antidepressants, although no youth have died by suicide. Compared to other pediatric psychiatric disorders, like obsessive compulsive disorder or anxiety, the mean effect of SSRIs for depression has demonstrated lower efficacy (Locher et al., 2017). When examined in adult populations, pharmacotherapy has been shown to be more efficacious than placebo (Ryan, 2005). However, pediatric patients who are prescribed medications, specifically fluoxetine are less likely to relapse following treatment. Additional studies evaluating acceptability of pharmalogical treatments have found that Prozac is associated with less dropouts during treatment and combining Prozac with cognitive behavioral therapy is considered most effective for adolescent depression (Zhou et al., 2020). Additionally, for severe depression, the literature suggests combining psychotherapy and selective serotonin reuptake inhibitors (SSRIs).

Treatment Outcomes for Depression in Hispanic Youth

The literature surrounding efficacy of treatments for ethnically or racially diverse youth with depression continues to grow, but studies examining specific treatments for minoritized youth remains

scant. Pina et al. (2019) completed a review of psychosocial interventions for ethnic minority youth and found the literature continues to focus on intervention effectiveness for White Non-Hispanic youth, with examinations of treatment effectiveness for racial and ethnic minority remaining limited. The research shows some support for the efficacy of CBT, BA, and IPT for Hispanic adolescents with depression. This continues to be an area of growth in the literature as many studies demonstrating effectiveness of a particular treatment do not have adequate representation of Hispanic youth and given barriers to accessing treatment for minoritized populations, studies with diverse participants can be difficult to replicate.

An earlier study examined changes in depressive symptoms in Puerto Rican adolescents (age 13 to 17 years) who were randomized to a waitlist condition, CBT, or IPT (Rosselló and Bernal, 1999). These participants were either diagnosed with Major Depression or Dysthymia. As part of the CBT or IPT conditions participants took part in weekly 1-hour therapy sessions for a 12-week period and were assessed at baseline, post-treatment, and a 3-month follow-up. Both CBT and IPT, improved depressive symptoms significantly and there were no significant differences in symptom improvement. However, for the IPT group post-treatment, participants had reported having significantly higher functionality at post-treatment compared to the CBT group.

Another study examined the CBT and IPT outcomes and the modality (individual vs group therapies) in which each intervention was delivered to Puerto Rican adolescents screened for depression (Rosselló et al., 2008). These adolescents were aged 12 to 18 years and were referred from their local school. In contrast to earlier studies, findings from the study indicated that participants who were assigned to the individual and group CBT conditions had greater improvements in their depressive symptoms compared to those who were in the IPT individual or group conditions. However, for both the

IPT and CBT conditions, there were no significant differences found between the individual or the group modalities.

Gunlicks-Stoessel and Mufson (2011) conducted a study comparing IPT for Adolescents (IPT-A) to a treatment as usual (TAU) condition, with a sample (*n* = 63) of participants that were largely Latinx/e (74.6%). Participants were assigned to 12 weeks of IPT-A at a clinic located in a school and patient symptomology was assessed at multiple time points (4,8, 12, or 16 weeks). The IPT-A condition significantly reduced depressive symptoms when assessed at each time point and the study also found adolescents who had improved scores by week 4 in treatment were more likely to be in remission by week 16.

McGlinchey et al., (2017) conducted a study with a large sample of Hispanic adolescents who sought treatment for depression. The sample was mostly female (84%) and Hispanic (71%) and participants were placed into two conditions, IPT-A or TAU. This study found significant improvements in depressive symptoms for the IPT-A group compared to TAU. However, another variable that was included was sleep disturbance, which did not improve in the TAU or IPT-A conditions. This is significant because depressive symptoms are often predicted by persistent sleeping problems and may be an area for further research. However, McGlinchey et al.'s (2017) findings concerning the efficacy of IPT-A provides more support for its use.

Chu et al., 2016 conducted an additional study with a smaller sample (*n* = 35), which included 13 Hispanic participants who were between 12 and 14 years old who had comorbid anxiety and depressive disorders and were randomly assigned to a BA or control condition. Interventionists in the study delivered group BA to participants over 12 to 15 weeks in a school-based setting and compared outcomes to a waitlist control group. Participants were assessed at a pre-, post-, a 4-month follow-up. Researchers in the study could not perform statistical tests on depressive symptoms due to the small

sample size but found six youth met criteria for a depression diagnosis pretreatment, two at posttreatment, and zero at follow-up. Additionally, youth reported significant decreases in impairment and negative thoughts post-treatment and at follow-up.

Treatment Satisfaction

The literature shows that children from minoritized groups with internalizing concerns (e.g., anxiety or depression) are less likely to receive treatment than minoritized children with externalizing problems (e.g., oppositional or disruptive behaviors) and youth are less likely to seek treatment if they have had past unfavorable experiences within health systems (Gudiño et al., 2009; Vogel et al., 2011; Zimmerman, 2005). Further, those who are less satisfied with care are more likely to drop out of treatment (de Haan et al., 2017). Despite this evidence, the literature surrounding treatment satisfaction among minoritized youth is scant and definitions of treatment satisfaction vary between studies.

A qualitative analysis was conducted to review patient satisfaction questionnaires and the most frequent areas assessed for satisfaction in patients following treatment (Miglietta et al., 2018). Researchers found most scales included items surrounding patient's relationship with staff, perceived outcomes following treatment including improved mental health, and feeling as if the staff were reliable and knowledgeable. This review found differences in the scales based on the level of treatment. For example, for the inpatient level of care feelings of safety was another item that was included in assessments. Given the variability in the scales used and how treatment satisfaction is assessed, there has not been an identified definition for treatment satisfaction (Miglietta et al., 2018).

Generally, the literature has suggested that satisfaction with treatment is an important variable to consider in that satisfaction with treatment can be linked to lower dropout rates and increased

compliance with treatment targets. Constantine (2002) found that for 112 college students of color, perceptions of increased multicultural competence accounted for a significant amount of the variance in client satisfaction ratings, along with client's attitudes towards counseling in general, the therapist's ability to form effective working alliances with clients, and the therapist's perceived empathy. Another study examined 325 adult patients receiving mental health services in interdisciplinary treatment centers (Fortin, 2018). Researchers found factors such as continuity of care, having a case manager and receiving additional help from providers for daily or social needs, like assisting with self-care, food, money, and help finding a job to be contributors to satisfaction in adult patients (Fortin, 2018).

Cultural Sensitivity and Treatment Outcomes

Given the increasing awareness of incorporating multicultural perspectives within different therapeutic approaches, studies have examined traditional treatment approaches and how to tailor them to diverse client populations. Studies have found that minoritized youth report a lack of trust and disinformation when seeking mental health services and feel as if mental health professionals often lack cultural sensitivity and knowledge of their individual cultures (Ijadi-Maghsoodi et al., 2018). Thus, making this a needed area of research.

Cultural Adaptions. The literature suggests a way to make treatment more effective is to use culturally adapted treatment approaches, which include continuing to use evidence-based intervention components for diverse clients but tailoring them to the values or customs of their individual cultures (Hall et al., 2016). Researchers found culturally adapted treatments were more effective than a different nonadapted treatment, a nonstandardized treatment, and no treatment when a review of 78 studies was conducted (Hall et al., 2016). Typically, cultural adaptions make treatment more accessible or understandable for youth of color. For Hispanic youth, this may involve delivering the intervention in the child's preferred language.

Other adaptations can include affirming and acknowledging the impact of oppression on the youth's different identities and mental health. One can use terms or analogies to ensure diverse youth can make informed decisions about their treatment and better understand therapy techniques (Graham et al., 2014). Functional assessments can also be used to identify the antecedents and consequences related to a client's stressors and identify environmental factors contributing to stress. When in treatment, providers utilizing a culturally adapted approach validate client's experiences of oppression rather than attempting to explore other hypotheses as typically done in cognitive restructuring. Therefore, a CBT therapist would have to consider shifting away from teaching the client about faulty or irrational thinking patterns. Finally, therapists may also consider bringing up conversations surrounding experiences of marginalization during the first therapy session and continuing to incorporate open discussions about these stressors throughout the duration of treatment (Graham et al., 2014).

Ethnically or racially matching clients and providers has been another cultural adaptation commonly utilized in treatment. Clients did report preferring providers who were of the same cultural background, but in terms of treatment outcomes (i.e., improving symptoms) little to no benefits came from having a provider of the same culture. However, the greatest benefit of ethnic matching occurred during initial sessions of therapy when the therapeutic alliance was being formed, which made clients more likely to attend initial sessions (Smith & Cabral, 2011).

Provider Trainings in Culturally Sensitive Approaches. Studies have investigated the effectiveness of trainings aimed to help providers navigate patients' cultures when providing care. Methods of training have been several approaches like documentaries, case vignette discussions, video demonstration, cultural discussion in rounds, and traditional teaching methods (Mills et al., 2017; Vyjayanthi et al., 2021). Outcomes following trainings have included self-reported increases in understanding of their patient's cultural experiences, cultural self-awareness, empathy, as well as

improvements in nonverbal communication after the trainings (Mills et al., 2017; Vyjayanthi et al., 2021). The behavioral health clinics developed a training in culturally sensitive approaches, specifically focused on allyship and belonginess. This training was launched in January of 2022 as a requirement for all staff and staff were required to participate in the training once per year.

The behavioral health clinics' providers and staff underwent a 5-part training in belongingness and allyship. Part 1 of the trainings for providers were discussing the foundational concepts of bias and privilege, which defined these concepts, provided scenario examples of privilege, and reasons why colorblindness is an ineffective approach to health equity. Part 2 of the training focused on exploring multiple perspectives, learning to listen to others, and learn about differences or similarities in cultures. Part 3 discussed concepts related to unconscious bias, exercises to identify providers' own biases, and steps on how to reduce bias. Part 4 of the training focused on bystander behaviors as an ally or ways to challenge discriminatory approaches or actions. Part 5 of the training discussed allyship in action and common pitfalls, which provided learning content to providers on ways to learn about other people without offending others. This part as provided education on microaggressions. Providers were provided with learning content for each part through videos. Then, they were able to engage in conversation about the themes presented through the content with colleagues. Discussions were led by facilitators in the clinics' Equity, Diversity, and Inclusion department, as well as a member of the allyship and belongingness team who volunteered to co-facilitate the discussions. Prior to leading discussions with behavioral health clinic employees, facilitators took part in the allyship and belongingness training as a team and engaged in discussion. It should be noted that the data used in the study were collected from 2018-2023. Therefore, some patients received treatment from providers who did not yet undergo the allyship and belongingness training. We cannot conclude that the findings related to satisfaction were the result of the staff-focused training on allyship and belonginess.

Summary

Literature surrounding depression has found treatment approaches like IPT and CBT effective for reducing symptoms, with IPT being more frequently studied among Hispanic youth (Rosselló & Bernal, 1999; Rosselló et al., 2008; McGlinchey et al., 2017). For BA, only one study with adequate representation of Hispanic individuals was found and the results were promising for improving functioning and symptoms. Regarding treatment satisfaction, several factors have been found to contribute to client satisfaction including perceived cultural awareness, continuity of care, tending to other social or personal needs, and therapeutic alliance. The current literature points to the importance of treatment satisfaction, as minorized youth may drop out of treatment and be less likely to seek mental health services in the future. However, treatment satisfaction and the use of BA with Hispanic samples has been understudied. The current study aimed to fill this gap by examining Hispanic adolescents' level of satisfaction following BA treatment and determining the association between levels of cultural sensitivity, satisfaction, and treatment outcomes.

Chapter 3: Methods

The goal of this study was to examine the efficacy of Behavioral Activation (BA) for Hispanic adolescents' depressive symptoms and quality of life. This study was a follow-up study of Morgan and researchers' (2021) study that compared the efficacy of BA for different ethnic/racial groups. These included African American/Black, Hispanic, and European American/White adolescents. Extending beyond the objectives of the previous Morgan et al. (2020) study, the current study sought to understand the relationship between patient satisfaction with BA treatment and treatment outcomes. It should be noted that a feature of the setting was providers were required to undergo a training in allyship and belongingness starting in January of 2022. Providers completed this series of allyship and belongingness trainings to increase their knowledge of concepts like privilege, bias, microaggressions, and completed cultural discussions with colleagues surrounding these concepts. These data were retrieved from the last 5 years, due to the start of administration of the Patient Satisfaction Survey being in 2018. Therefore, some clinicians provided the intervention before they received the training in allyship and belongingness. Patients were asked to complete surveys rating their satisfaction with care overall and satisfaction with the provider's level of cultural sensitivity. Therefore, the study also examined participant's satisfaction with the cultural sensitivity of providers and overall satisfaction with care at the behavioral health clinics. However, participants in the study
may have not received treatment by providers who underwent the allyship and belongingness training.

This study was conducted using archival data collected as part of the behavioral health facility's intake and discharge assessment procedures. The overarching purpose of collecting data as part of routine intake and discharge procedures was to make treatment decisions related to patient care upon admission, monitor changes in progress, and prepare patients for discharge. This chapter describes the

participants of the study, provides details regarding the setting in which treatment took place, and outcome measures used for analysis. Additionally, this chapter discusses the study procedures and proposed statistical analyses.

Participants

Patient data used in the study included those who received mental healthcare at behavioral health clinics throughout the United States. Patients who are referred to these behavioral health clinics have depressive symptoms that have impaired their ability to function in their daily lives. Referral sources can include outpatient therapists or inpatient hospitals. Further information about the clinicians who provided treatment to the participants was protected and could not be released for the purposes of research. Therefore, information regarding if patients had the same clinician throughout the duration of their treatment could not be accessed.

Participants included in the current study selected their ethnic identity as Hispanic on the Admissions Screening Interview (ASI) upon admission. Additionally, participants were further narrowed to include only patients who were between 11 and 21 years of age, who had a primary or secondary diagnosis of Major Depressive Disorder and received BA treatment for depression. These archival data were sourced from the behavioral health clinic database after completing a request for these specific deidentified records and following approval from the Institutional Review Board (IRB).

Exclusion Criteria. Patients who did not complete the outcome measures used in this study during intake or discharge were excluded from the study. Due to the way the dataset was provided to the PI, further analyses on comparisons between those excluded and not excluded could not be completed.

Setting. Participant data retrieved for this study were sourced from a larger database maintained by the behavioral health clinic. Participants completed the outcome measures at admission, throughout treatment, and prior to discharge. The outcome measures selected were part of this

standard protocol of data collection. These data are used to inform the multidisciplinary treatment team on the patients' severity of symptoms and response to BA treatment.

Patients who receive services at the clinics are assigned to different levels of care. These include residential, partial hospitalization, or intensive outpatient levels. For the residential level of care, patients are in treatment for 24 hours/day and attend 7 days per week. Partial hospitalization involves patients receiving treatment 6 hours/day and 5 days/week. The intensive outpatient level entails patients participating in treatment for 3 hours/day and 5 days per week. Based on patients' referral concern (i.e., depression) they are assigned to the depression recovery program in which clinicians provide them with BA treatment. Each clinician utilizes a manualized BA protocol which is standardized across behavioral health clinics. This manual includes an overview of BA, psychoeducation materials, instructions for delivering the BA intervention, and includes patient worksheets.

Behavioral Activation Treatment

Behavioral Activation (BA) is the treatment provided to youth who are assigned to the depression recovery program. Behavioral specialists are trained in a manualized protocol which includes a structured set of procedures for implementation. These procedures include providing psychoeducation to the patients regarding their depressive symptoms as well as BA treatment. This includes detailing how their current actions (e.g., isolation, withdrawal) maintain and worsen their depressive symptoms as well as their life circumstances (e.g., having less friends, lower grades). Patients then are presented with a behavioral chain analysis activity, where they can select the antecedents and consequences of their depressed behaviors. These depressed behaviors may include behaviors like skipping school, self-harm, or isolating themselves from others. Patients then learn alternative coping strategies to use in place of these maladaptive behaviors. The BA protocol also involves pleasant event scheduling where patients can identify their values and the areas of their lives their depressive symptoms have affected them most (e.g., relationships with peers, family). With their behavioral

specialist, patients then engage in activity scheduling to select pleasant, routine, and valued activities they would be willing to engage in to improve their symptoms. Homework assigned to patients includes completing these scheduled activities and rating their mood before and after each planned activity. Patients also review with their behavioral specialist a troubleshooting form, which allows the patient to problem-solve any perceived barriers to completing their scheduled activities. During treatment, patients are introduced to additional skills to improve problem-solving and communication. Prior to discharge, patients complete and review their relapse prevention form. For relapse prevention, patients plan for anticipated challenges in the future or potential triggers in their daily lives, identify warning signs for depression, review strategies they have found helpful during treatment, and plan for their continued use.

Research Design

To address the research questions of the study, a non-experimental correlational design was used. The research questions were answered using a demographics screening measure and outcome measures which assess depressive symptom severity, quality of life, and satisfaction with treatment.

Measures. Four measures were included as part of the data collection: the Admissions Screening Interview, the Patient Satisfaction Questionnaire, the Pediatric Quality of Life Enjoyment and Satisfaction Questionnaire, and the Quick Inventory of Depressive Symptomology. The following provides a description of each of the questionnaires used.

Admissions Screening Interview. The Admissions Screening Interview (ASI) is a measure developed by the behavioral health facility used to gather demographic data about patients. It was administered by an intake specialist prior to patients beginning treatment. The ASI queries about demographic information like race, ethnicity, age, pronouns, employment status, and gender identity. Patients also were asked for descriptive information about their prior treatment history, prior level of

treatment (e.g., partial hospitalization, residential, inpatient). Additional questions were generated from patient responses on this survey. Therefore, the number of items was determined by patient responses.

Quick Inventory of Depressive Symptomology. The Quick Inventory of Depressive Symptomology (QIDS) is a 16-item self-report survey used to measure depression symptom severity and the presence of depressive symptoms. Items on this scale are aligned with DSM-IV criteria which include sad mood, trouble concentrating, lack of interest, thoughts of suicide, self-criticism, decreased energy, sleep disturbance, changes in appetite, psychomotor changes (Rush et al., 2003). Patients were able to indicate a score from 0 to 3 and higher scores reflect more severe symptoms. Total scores on the QIDS can range from 0 to 27. The current study used patient's total scores to examine treatment outcomes. The QIDS is a shortened version of the 30 item, Inventory of Depressive Symptomology (IDS; Rush et al., 2003). Rush et al. (2003) found high correlation (r = .96) and high internal consistency (α =.86) between the QIDS and the IDS. Additionally, the Hamilton Rating Scale for Depression was also shown to be highly correlated with the QIDS (r = .86*).*

Pediatric Quality of Life and Satisfaction Scale. The Pediatric Quality of Life and Satisfaction Scale (PQ-LES-Q) is a 15-item measure developed by researchers to assess life enjoyment for youth in different domains like at school or home (Endicott, Nee, Yang, & Wohlberg, 2006). Response options range from "very poor" to "very good" and the total score ranges from 14 to 70 with higher scores indicating greater satisfaction and enjoyment in life. The PQ-LES-Q was adapted for youth from the Quality of Life and Satisfaction Scale used for adults. The PQ-LES-Q has been shown to be moderately correlated with the Children's Depression Rating Scale (r = 0.45) and the Children's Global Assessment Scale *(r =*.36; Endicott, Nee, Yang, & Wohlberg, 2006). High internal consistency has also been found with the PQ-LES-Q, with Cronbach's alphas at screening, baseline, and endpoint of 0.87, 0.90, and 0.89, respectively. Additionally, the test-retest intraclass correlation coefficient of reliability (r= 0.78) also was found to be high for the PQ-LES-Q measure.

Patient Satisfaction Survey. The patient satisfaction survey is a 21-item questionnaire and was developed by the behavioral health facility. This survey is included as part of the standardized measures administered to patients prior to discharge. The purpose of the survey is to assess patient level of satisfaction with the behavioral health clinic, and it assesses patient attitudes in several areas including clinic meals, specific providers, cultural sensitivity, and their care overall. The survey uses the same scale for each question with the following response options: very dissatisfied, dissatisfied, neither satisfied nor dissatisfied, satisfied, and very satisfied. Each patient response was assigned a numerical identifier (e.g., very dissatisfied = 0, very satisfied=4). In this case, higher numbers will indicate greater satisfaction. A total score is computed by averaging the responses. The possible range of total scores on the Patient Satisfaction Survey are between a 0 to 4.0. A score of 0 represents a complete lack of dissatisfaction, 0-1 represents very dissatisfied, and a score between 1-2 represents that a patient is overall more dissatisfied than satisfied. 2-3 indicates a patient is more satisfied than dissatisfied and a score of 3-4 represents a patient is very satisfied. A score of 4 represents complete satisfaction. It should be noted that clinic procedures included patients debriefing with a staff member if they had ratings on the Patient Satisfaction Survey below a 3. This procedure may have resulted in higher ratings on the Patient Satisfaction Survey for patients who did not want to engage in this debriefing. The current study utilized two questions from the survey. The first item used asks patients to rate their overall satisfaction with their care at the behavioral health clinic. The second survey item used asks patients to rate their satisfaction with the staff's level of cultural sensitivity.

Procedures

This study was an analysis of archival data from the behavioral health clinic's database. Inferential analyses were conducted to address the proposed research aims of the study and the individual participants were the units of analysis. Following approval of the study proposal by the doctoral dissertation committee, an application for approval to the University of South Florida (USF) IRB

were submitted. An additional IRB application was submitted to the IRB of the behavioral health clinic. A data request form was then sent to the behavioral health clinic so that the encrypted data set can be sent to the Principal Investigator (PI). Data were requested regarding the patients as well as the A data use agreement was sent to committee members and the PI.

The deidentified dataset was sent to the PI over a secure server and was accessed on a password-protected laptop with an encrypted hard drive. After the dataset was sent to the PI, the Excel document was reviewed to ensure the data received were consistent with the data request. The Excel document was reviewed for missing data.

Data Analyses

For the current study, an analysis of patients' depressive symptom severity, patient quality of life, and satisfaction following treatment occurred to answer the following questions.

Question 1. How did Hispanic adolescents respond to Behavioral Activation (BA) treatment, as evidenced by changes from admission to discharge in depressive symptoms and health-related quality of life? Data from the PQ-LES-Q and the QIDS was used to determine patients' response to treatment. Analyses will include paired samples t-tests of global PQ-LES-Q scores pre- and post- BA treatment, as well as global QIDS scores pre- and post-BA treatment.

Question 2. How satisfied were Hispanic adolescents with intensive BA treatment, both overall and as being sensitive to their cultural identity? To determine patients' satisfaction with treatment overall and patient satisfaction with treatment being sensitive to their cultural identity, mean scores was calculated for both items on the Patient Satisfaction Survey. For analyses, each patient response option was assigned a numerical identifier (e.g., very dissatisfied = 1, very satisfied=5).

Question 3. What is the relationship between treatment outcomes and satisfaction with care overall? To determine the relationship between satisfaction with care and treatment outcomes, change scores for pre- to post- treatment on the PQ-LES-Q and the QIDS were used. These change scores were

calculated by deducting the pre-treatment score from the post-treatment scores. A correlational analysis were then conducted using patient scores with satisfaction with care overall and the calculated change score on the PQ-LES-Q. An additional correlational analysis was conducted using patient scores with satisfaction with care overall and the calculated change score on the QIDS. Pearson's correlation coefficients were used to determine how strong the relationship is between the two variables.

Question 4. What is the relationship between treatment outcomes and satisfaction with providers' levels of cultural sensitivity? To determine the relationship between satisfaction with providers' levels of cultural sensitivity and treatment outcomes, change scores for pre- to post-treatment on the PQ-LES-Q and the QIDS were used. A correlational analysis was conducted using patient scores with providers' levels of cultural sensitivity and the calculated change score on the PQ-LES-Q. An additional correlational analysis was conducted using patients scores for providers' levels of cultural sensitivity and the calculated change score on the QIDS. Pearson's correlation coefficient was used to determine how strong the relationship is between the two variables.

Ethical Considerations. Due to the current study being an analysis of archival data, precautions were taken to protect patient confidentiality. The data request was made for de-identified data and was sent to the PI with no HIPAA identifiers. The data were accessed on a password-protected computer and the Excel document was also be encrypted. IRB approval from both USF and the behavioral health clinic were requested prior to beginning the analyses. Findings from the study may generate further support for the need for culturally sensitive practices when delivering psychotherapeutic interventions as well as provide more support for BA treatment for diverse adolescents.

Chapter 4: Results

The purpose of this study was to examine the efficacy and treatment satisfaction with Behavioral Activation (BA) among Hispanic/Latinx adolescents by analyzing data from measures assessing symptom severity, patient quality of life, and satisfaction following treatment. Data for this study were collected as part of routine intake and discharge procedures at behavioral health facilities across the US. The research questions that guided this study were as follows:

1. How did Hispanic adolescents respond to Behavioral Activation (BA) treatment as evidenced by changes in depressive symptoms and health-related quality of life from admission to discharge?
2. How satisfied were Hispanic adolescents with intensive BA treatment, both overall and as being sensitive to their cultural identity?
3. What is the relationship between treatment outcomes and satisfaction with care overall?
4. What is the relationship between treatment outcomes and satisfaction with providers' levels of cultural sensitivity?

Specifically, this chapter first reviews the procedures utilized to ensure the validity of the data and the preliminary analyses. Then, the results of a series of paired samples *t*-tests are presented to evaluate changes in depressive symptoms and health-related quality of life from pre- to post-BA treatment. Next, calculations of means and confidence intervals for patient satisfaction with care overall and satisfaction with providers' level of cultural sensitivity are shared. Calculations of means and confidence intervals also are divided by three adolescent age groups (e.g., early [11-14 years], middle [15-17 years], and late [18-21 years] adolescence). Finally, the correlational analyses among variables to

examine the relationship between patient satisfaction with care overall and treatment outcomes (e.g., changes in symptom severity, changes in quality of life) are provided, and correlational analyses to examine the relationship between satisfaction with providers' level of cultural sensitivity and treatment outcomes are presented.

Data Screening

The dataset retrieved from the behavioral health clinic's research database included 1,875 participants who were part of BA treatment at behavioral health clinics throughout the U.S. Out of the 1,875 patients included in the dataset, 155 patients identified as Hispanic and were included in the analyses. The remaining 1,720 patients were excluded because they identified as non-Hispanic. Due to the way the dataset was provided to the PI, further analyses on comparisons between those excluded and not excluded could not be completed. Data collected from adolescents who were part of BA treatment, as well as survey responses on the Patient Satisfaction Survey, the QIDS, and PQ-LES-Q were reviewed.

Missing Data. Methods used in the clinics to reduce missing data included scanning electronic surveys for completion using an electronic database, as well as requesting that participants complete portions of the survey that were incomplete. Therefore, patients who accidentally missed or incorrectly answered were prompted to revisit the measure. However, patients had to option to not complete the measures. The dataset was reviewed to ensure all requested variables were present. Then, the dataset was imported into SPSS and checked for entry errors. A period was automatically inserted into cells with missing data by the SPSS system. Inserting a period into cells with missing data ensured these missing data were not included in the analyses.

Different measures had different amounts of missing data. For example, the Pediatric Quality of Life and Enjoyment Questionnaire and the Quick Inventory of Depressive Symptomology were fully completed by all patients (n = 155) included in this study. However, question 10 on the Patient

Satisfaction Survey, asking patients to rate their “overall level of satisfaction with your care,” was completed by 72 out of 155 patients (46% of patients). For question 21 on the Patient Satisfaction Survey which asked patients to rate “How satisfied are you regarding staff's cultural sensitivity to your identity”, 62 out of 155 patients responded (40% of patients).

Preliminary Analyses

Preliminary analyses consisted of computing Cronbach’s alphas for the multi-item scales, as well as computing descriptive statistics (e.g., means, standard deviations, skewness, kurtosis) for all variables of interest.

Normality. To assess univariate normality, skewness and kurtosis of the variables were calculated. All of the variables had an approximately normal distribution (skew and kurtosis between -2.0 and +2.0). Given these results, the distribution for each of these variables was considered acceptable. The normality assumption for the dependent samples t-test was also examined and the change scores for the outcome variables (i.e., quality of life and depressive symptom severity) were also approximately normal with a skew and kurtosis between -2.0 and +2.0.

Measure Reliability. Internal consistency was examined for the Patient Satisfaction Survey using the 2 items (questions 10 and 21) used in the current study. The coefficient alpha for the Patient Satisfaction Survey was an 0.66, which fell in the acceptable range (> .60). The Pediatric Quality of Life and Enjoyment Questionnaire had a coefficient of 0.63 and the Quick Inventory of Depressive Symptomology (QIDS) had a coefficient of 0.79. Both the PQ-LES-Q and the QIDS both fell in the acceptable range. Skewness and kurtosis of the outcome variables are listed below in Table 1.

Table 1

Skewness and Kurtosis of the Outcome Variables

Measure	Skewness	Kurtosis
Patient Satisfaction Survey		
Question 10	-.82	.68
Question 21	-1.26	.99
Pediatric Quality of Life and Enjoyment Questionnaire		
Pre- Total Score	.19	-1.06
Post- Total Score	-.29	-.33
Quick Inventory of Depressive Inventory Symptomology		
Pre- Total Score	-.54	-.21
Post- Total Score	.52	-.40

Patient Information

The Primary Investigator (PI) of this study requested data of patients who had received BA services at behavioral health clinics throughout the United States. The final sample included 155 participants (*M*= 16.5 years old; range of 11 to 21 years old). In total, the data set included participants from 19 behavioral health clinics throughout the United States. Fifty-one percent of patients lived in the Midwest, 3% lived in the Northeast, 37% lived in the South, and 9% of patients reported living in the Western region of the United States (Substance Abuse and Mental Health Services Administration, [SAMSHA], 2011). Information regarding the percent of patients with private insurance or patient socioeconomic status was not provided in the dataset received.

In regard to ethnicity, all patients identified as Hispanic. Regarding race, of the 155 participants, 83.9% identified as White, 6% as Unknown, 4% as other, and 2% as Black. Patients also identified their sex at birth with 69% of the sample reported as female and 31% male. Regarding gender identity, 57% of participants identified as female, 27% identified as male, 8% identified as transgender or nonbinary, and 1% identified as gender fluid. For 7% of patients their gender identity was noted as unclear or unknown, which occurred when patients did not answer this item or selected more than one gender identity.

The most common primary diagnoses were recurrent, severe Major Depressive Disorder (*n*=44) and recurrent, moderate Major Depressive Disorder (n=21). For secondary diagnoses, the most frequent diagnoses among the sample were Generalized Anxiety Disorder (*n* = 41) and Social Anxiety Disorder (*n*= 34). The percentages of patients who were in residential care, partial hospitalization, and intensive outpatient were 25% (*n*= 38), 56% (*n*= 87), and 19% (*n*= 30), respectively. The mean length of stay at the behavioral health clinics was 26 days (*SD* = 15.66) for the sample. A summary of descriptive statistics is presented in Table 2.

Table 2

Descriptive Characteristics of Patient Sample at the Participating Behavioral Health Clinics (*n*= 155)

Demographic Characteristic	*n*	%
Gender		
Male	41	27%
Female	89	57%
Transgender male	5	3%
Transgender female	1	1%
Nonbinary	6	4%
Gender Fluid	2	1%
Unknown/Unclear	11	7%
Race		
White	130	84%
Black	3	2%
Mixed	3	2%
Unknown	9	6%
Other	6	4%

For additional analyses, data from the patients were divided into three age groups (early, middle, and late adolescence). These three categories and specific age ranges are consistent with categories used in other studies with adolescent participants (and then cite here a couple of studies that used the same age ranges). Table 3 displays the number of participants whose data corresponded to each of the three groups.

Table 3

Number of Patients Whose Data Corresponded to the Three Age Groups

Stage of Adolescence	*n*	%
Early Adolescence (11-14)	40	25.8%
Middle Adolescence (15-17)	56	42.6%
Late Adolescence (18-21)	49	31.6%

Research Question 1

Research question 1: How did Hispanic adolescents respond to Behavioral Activation (BA) treatment as evidenced by changes in depressive symptoms and health-related quality of life from admission to discharge?

Mean Comparisons for the Overall Sample. A paired samples t-test was conducted to compare means for the sample's Quick Inventory of Depressive Symptomology (QIDS) scores pre- and post-treatment. There was a significant reduction in depressive symptoms following BA treatment [t (154) =13.31, $p < 0.001$]. The QIDS is a measure with total scores that can range from 0 to 27. Scores of 5 or lower indicate no depression. Scores ranging from 6 to 10 represent mild depression, 11 to 15 indicate moderate depression, and 16 to 20 reflect severe depression. Total scores of 21 or above indicate very severe depression. The mean total QIDS score for participants prior to treatment was 14.21 (*SD* = 5.53) indicating moderate depression. Following treatment, the mean QIDS score was 8.31 (*SD* = 5.70*)* indicating mild depression.

Likewise, an additional paired samples *t*-test was completed to compare means for the pre- and post- PQ-LES-Q scores. There were significant improvements in health-related quality of life following BA treatment when comparing pre- and post- PQ-LES-Q scores [t (154) =-12.06, $p < 0.001$]. Patient responses on the Pediatric Quality of Life and Satisfaction Scale (PQ-LES-Q) can range from "very poor"

to “very good”, with total scores ranging from 14 to 70 and higher scores indicating greater enjoyment and satisfaction in life. Before treatment, the mean total PQ-LES-Q score for the sample was 34.79 (*SD* = 26.67*).* Following treatment, the mean total PQ-LES-Q was 62.33 (*SD* = 19.83*)*.

The Cohen’s *d* standardized effect size for health-related quality of life was a .96 (baseline *SD* =18.67) indicating a large effect size (>.80). For depressive symptom severity, Cohen’s *d* standardized effect size was a 1.07 (baseline *SD* = 5.53) also indicating a large effect size. These results suggest overall, there was a significant improvement in health-related quality of life and depressive symptoms following BA for all Hispanic adolescents in this sample following BA treatment. Table 4 displays the results of the paired samples *t*-tests.

Table 4

Results of the Paired Samples T-Tests

Measure	*Pre-treatment*		*Post-treatment*		*t*(154)	*P*	Cohen’s *d*
	M	*SD*	*M*	*SD*			
Pediatric Quality of Life and Satisfaction Scale (PQ-LES-Q) Total Score	34.79	26.67	.877	.082	-12.06	< 0.001	0.96
Quick Inventory of Depressive Symptomology (QIDS) Total Score	62.33	19.83	.002	.0002	13.31	< 0.001	1.07

Mean Comparisons by Age Group. A repeated measures analysis of variance was completed to compare changes in depressive symptoms between the three adolescent age groups (e.g., early [11-14 years], middle [15-17 years], and late [18-21 years] adolescence). Two time points were included in the analyses, pre- and post- treatment. BA treatment had a statistically significant effect on depressive symptoms from pre- to post-treatment, F (1, 152) = 168.047, p <.001. A Tukey’s test was completed to

compare means between the three age groups. There were not significant differences in changes in depressive symptoms for the three adolescent age groups. Table 5 includes the results of the repeated measures analysis of variance and Tukey's test for changes in depressive symptoms using the QIDS.

Table 5

Tukey's Test Results for Changes in Depressive Symptoms for the Three Adolescent Groups

Age Group	Comparison Group	Mean Difference*	*p*
Early Adolescents	Middle Adolescents	1.68	.20
	Late Adolescents	.24	.97
Middle Adolescents	Early Adolescents	-1.68	.20
	Late Adolescents	-1.43	.26
Late Adolescents	Early Adolescents	-.24	.97
	Middle Adolescents	1.43	.26

*Mean difference scores= Age group - comparison group

Regarding quality of life, there were significant differences in changes of quality of life from pre- to post. More specifically, late adolescents had significantly greater changes in quality of life from pre to post when compared to middle adolescents and early adolescents. Results of the Tukey's test for health-related quality of life are included in Table 6.

Table 6

Tukey's Test Results for Changes in Health-Related Quality of Life for the Three Adolescent Groups

Age Group	Comparison Group	Mean Difference*	*p*
Early Adolescents	Middle Adolescents	-4.28	.32
	Late Adolescents	21.81	<.001
Middle Adolescents	Early Adolescents	4.29	.32
	Late Adolescents	26.10	<.001
Late Adolescents	Early Adolescents	-21.81	<.001
	Middle Adolescents	-26.10	<.001

*Mean difference scores= Age group - comparison group

Research Question 2

Research question 2: How satisfied were Hispanic adolescents with intensive BA treatment, both overall and as being sensitive to their cultural identity? To answer research question 2, means and confidence intervals were calculated for two statements patients were asked to rate on the Patient Satisfaction Survey. These were: "overall level of satisfaction with your care" and "How satisfied are you regarding staff's cultural sensitivity to your identity (Age, Disability Status, Religion, Ethnic and Racial Identity, Socioeconomic Status, Sexual Orientation, Indigenous Heritage, National Origin, Gender Identity, etc.)?"

The research department at the behavioral health clinics provided the PI with scoring procedures used by clinicians and researchers to determine patient satisfaction. Total scores are calculated by averaging the responses on all items. The current study did not compute total scores but examined the mean responses of patients for two individual items. A codebook was provided to the PI with instructions on the scoring for the internally developed Patient Satisfaction Survey. The possible

range of scores on the Patient Satisfaction Survey are between a 0 to 4.0. A score of 0 represents complete dissatisfaction, 0-1 represents very dissatisfied, and a score between 1-2 represents that a patient is overall more dissatisfied than satisfied. A rating of 2-3 indicates a patient is more satisfied than dissatisfied and a score of 3-4 represents a patient is very satisfied. A score of 4 represents complete satisfaction.

The first question examined on the Patient Satisfaction Survey asked patients to rate their "overall level of satisfaction with your care" with response options ranging from "very dissatisfied" to "very satisfied." The overall sample had a mean response of a 3.00 (*SD* = .90), which fell in the very satisfied range. One patient (0.6%) selected a "0" when asked to rate their "overall level of satisfaction with your care" and 3 patients (1.9%) selected a 1. Fourteen patients (9%) responded with a "2". Thirty-one patients (20%) rated this item a "3." Twenty-three patients (14.8%) rated this item a "4."

When asked "How satisfied are you regarding staff's cultural sensitivity to your identity" the mean response from patients was a 3.47 (*SD* = .74), which also fell in the very satisfied range. No patients selected a "0" when asked "How satisfied are you regarding staff's cultural sensitivity to your identity." One patient (.6%) selected a "1," 6 patients (3.9%) selected a "2," 18 patients (11.6%) responded with a "3," and 37 patients (23.9%) rated this item a "4."

For the adolescent age groups, an additional one-way analysis of variance was completed to compare the means of patient ratings on the Patient Satisfaction Survey items post-treatment. For the first question examined on the Patient Satisfaction Survey, which asked patients to rate their "overall level of satisfaction with your care," middle adolescents had a significantly higher satisfaction than late adolescents. Table 7 summarizes the results of the one-way analysis of variance for patient ratings for their overall satisfaction with their care.

Table 7

One-Way Analysis of Variance Results for Patient Ratings of Their "Overall Satisfaction with Their Care"

	Sum of Squares	*df*	*Mean Square*	*F*	*p*
Between Groups	5.25	2	2.63	3.44	0.38
Within Groups	52.74	69	.76		

For the second question examined which asked "How satisfied are you regarding staff's cultural sensitivity to your identity" there were not significant differences in how patients responded based on age group. Table 8 summarizes the results of the one-way analysis of variance for patient ratings regarding their satisfaction of staff's cultural sensitivity to your identity.

Table 8

One-Way Analysis of Variance Results for Patient Ratings of Staff's Cultural Sensitivity to Their Identities

	Sum of Squares	*df*	*Mean Square*	*F*	*p*
Between Groups	.27	2	.14	.24	0.78
Within Groups	33.16	59	.56		

Table 9 includes a summary of patient responses for the two items on the Patient Satisfaction Survey for the overall sample and for the adolescent age groups.

Table 9

Mean Patient Satisfaction Survey Responses Post-Treatment by Age Groups

Age groups	Post-treatment			
	n	*M*	*SD*	95% CI
Early Adolescence (11-14)				
Overall satisfaction with care	21	2.90	.83	(2.54 to 3.25)
Satisfaction with cultural sensitivity	19	3.37	.68	(3.06 to 3.68)
Middle Adolescence (15-17)				
Overall satisfaction with care	31	3.29	.74	(3.03 to 3.55)
Satisfaction with cultural sensitivity	25	3.52	.77	(3.22 to 3.82)
Late Adolescence (18-21)				
Overall satisfaction with care	20	2.65	1.09	(2.17 to 3.13)
Satisfaction with cultural sensitivity	18	3.50	.79	(3.13 to 3.87)
Overall Sample				
Overall satisfaction with care	72	3.00	.90	(2.79 to 3.21)
Satisfaction with cultural sensitivity	62	3.47	.74	(3.29 to 3.65)

Research Question 3

Research question 3: What is the relationship between treatment outcomes and satisfaction with care overall? To examine the relationships between treatment outcomes (e.g., depressive symptom severity, health-related quality of life) and satisfaction with care, overall change scores for the outcome variables were calculated and Pearson product moment correlations were conducted. Results indicated changes in health-related quality of life were not significantly correlated with satisfaction with care overall (r = -.080, *p* =0.502). Table 10 summarizes the results of the correlational analysis between changes in quality of life and satisfaction with care overall.

Table 10

Correlations for Difference in Health-Related Quality of Life from Pre- to Post- and Patient Satisfaction with Care Overall

Variable	*N*	1	2
1. Health-related quality of life difference**	106	—	-.80
2. Patient satisfaction with care overall	52	−.80	—

*Correlation is significant at the 0.05 level; **Health-related quality of life difference = Pre-PQLES-Q total scores minus Post-PQLESQ total scores

In addition, changes in depressive symptom severity were not significantly correlated with patient satisfaction with care overall (r= .132, *p* = .268). Table 11 summarizes the results of the correlational analysis between changes in depressive symptoms from pre- to post treatment and satisfaction with care overall.

Table 11

Correlations for Changes in Depressive Symptoms from Pre- to Post-Treatment and Patient Satisfaction with Care Overall

Variable	*N*	1	2
1. Depression difference**	72	—	.132
2. Patient satisfaction with care overall	72	−132	—

*Correlation is significant at the 0.05 level; ** Depression difference = Pre-QIDS total scores minus Post-QIDS total scores

Research Question 4

Research question 4: What is the relationship between treatment outcomes and satisfaction with providers' levels of cultural sensitivity? The relationships between treatment outcomes (e.g., depressive symptom severity, health-related quality of life) and satisfaction with staff's level of cultural sensitivity change scores were also examined. Change scores for depressive symptom severity and health-related quality of life were calculated. Then, Pearson product moment correlations were completed. Results indicated changes in health-related quality of life were significantly and negatively correlated with satisfaction with staff's level of cultural sensitivity ($r = -.253$, $p < 0.05$). This result suggests that there was a significant negative correlation between participant changes in health-related quality of life and satisfaction with care following treatment.

Table 12

Correlations for Difference in Health-Related Quality of Life from Pre- to Post- and Patient Satisfaction with Staff's Level of Cultural Sensitivity

Variable	*N*	1	2
1. Health-related quality of life difference**	106	—	-.253*
2. Patient satisfaction with provider's level of cultural sensitivity	52	−.253*	—

*Correlation is significant at the 0.05 level; **Health-related quality of life difference = Pre-PQLES-Q total scores minus Post-PQLESQ total scores

However, changes in depressive symptom severity were not significantly correlated with patient satisfaction with staff's level of cultural sensitivity (r= .115, p =.373). Table 13 shows the correlation between changes in depressive symptoms and patient satisfaction with care as it relates to provider's cultural sensitivity.

Table 13

Correlations for Changes in Depressive Symptoms from Pre- to Post-Treatment and Patient Satisfaction with Provider's Cultural Sensitivity

Variable	*N*	1	2
1. Depression difference**	155	—	.115
2. Patient satisfaction with provider's cultural sensitivity	62	−.115	—

*Correlation is significant at the 0.05 level; ** Depression difference = Pre-QIDS total scores minus Post-QIDS total scores

Summary

The current study had four aims: 1) examine how Hispanic adolescents respond to Behavioral Activation (BA) treatment as evidenced by changes in depressive symptoms and health-related quality

of life from admission to discharge, 2) examine how satisfied Hispanic adolescents were with intensive BA treatment, both overall and as being sensitive to their cultural identity, 3) explore the relationship between treatment outcomes and satisfaction with care overall, and 4) examine the relationship between treatment outcomes and satisfaction with providers' levels of cultural sensitivity. Additionally, the study included a subgroup analysis to explore how adolescents in the early, middle, and late adolescence age groups responded to the intervention and responded to questions related to satisfaction with treatment. Overall, Hispanic adolescents had significant improvements in health-related quality of life and depressive symptom severity when comparing PQ-LES-Q and QIDS scores pre- and post- treatment. BA intervention resulted in large effect sizes for both health-related quality of life and depressive symptom severity. Most patients indicated being "satisfied" treatment (*M* = 3.00). The early and late adolescent age groups had a slightly lower rating for satisfaction with care overall and reported being "more satisfied than dissatisfied" with care. Additionally, the results indicated changes in health-related quality of life were significantly and negatively correlated with satisfaction with staff's level of cultural sensitivity. This means as changes in health-related quality of life increased, satisfaction with care as it related to cultural sensitivity decreased in the sample. It should be noted that clinic procedures included patients debriefing with a staff member if they had ratings on the Patient Satisfaction Survey below a 3. This procedure may have resulted in higher ratings on the Patient Satisfaction Survey for patients who did not want to engage in this debriefing. Therefore, results should be considered with caution. In addition, data used in the study were collected from 2018-2023 and the allyship and belonginess training began in January 2022. Therefore, some patients received treatment from providers who did not yet undergo the allyship and belongingness training. We cannot conclude that the findings related to satisfaction were the result of the staff-focused training on allyship and belonginess. There were not significant differences in changes in depressive symptoms for the three adolescent age groups, but late adolescents had significantly greater changes in quality of life from pre

to post when compared to middle adolescents and early adolescents. Further, middle adolescents had a significantly higher satisfaction ratings than late adolescents when rating their “overall level of satisfaction with your care.” In sum, BA treatment was found to be effective for Hispanic patients and patients largely reported being satisfied with their care overall and as it related to cultural sensitivity. Finally, a significant relationship was also found between health-related quality of life and satisfaction with care overall and satisfaction with care as it related to patient’s cultural identities.

Chapter 5: Discussion

Introduction

Prior studies have shown significant improvements in youth who complete Behavioral Activation (BA) treatment (Martin & Oliver, 2019). More research is needed to examine its effectiveness for culturally diverse populations, as lack of research on the applicability of interventions to culturally diverse populations can lead to premature dropout, less patient satisfaction, and decreased effectiveness of the intervention (Hall et. al, 2006; Olfson et al., 2009). This study aimed to examine treatment effectiveness, patient satisfaction, and the relationship between satisfaction and treatment outcomes for Hispanic adolescents. Providers of this BA treatment completed a series of trainings on allyship and belongingness. Patient satisfaction was explored in the context of care overall and as it relates to provider's sensitivity to patients' cultural identities. This study also explored patient satisfaction, as well as changes in symptoms from pre- to post-treatment using three adolescent groups (e.g., early [11-14 years], middle [15-17 years], and late [18-21 years] adolescence). This chapter details the study's findings and its implications. In addition, study limitations and recommendations for future research also will be discussed.

Demographic Characteristics

Ethnicity and Race. The sample was composed all Hispanic participants with the majority identifying racially as White (83.9%). Most of the sample identifying as White Hispanic is consistent with trends in Hispanic help-seeking and access to care (Cuevas et al., 2016). Hispanic people who identify as Black or Afro Latinos, typically are those of African ancestry, brown or dark skinned, or perceived by

others as racially Black (Cuevas et al., 2016; Logan, 2003). The finding that most participants in the study identified as White is significant in that the research suggests Black Hispanics have been shown to have a lower median household income, higher unemployment, higher poverty rate, and poorer health outcomes which may impact their ability to seek help in behavioral health settings. Studies have even shown Hispanic, Black female or Afro Latina adolescents have been found to report more severe depressive symptoms than their other Hispanic racial counterparts (Ramos et al., 2003). According to Cuevas et al. (2016), Black Hispanic people are typically grouped in with White or other races of Hispanics, which eliminates them from the health disparities discourse. Therefore, there is a need for further research on this Hispanic subgroup.

Gender. Most of the sample identified as female, consistent with prior studies that have shown females are more likely to seek mental health care (Smith et al., 2013). Men's help-seeking behaviors have consistently been shown to be lower even across ethnic and racial groups. Researchers have hypothesized this reluctance to utilize mental health services may be due to traditional norms of masculinity which emphasize self- reliance (Addis & Mahalik, 2003). *Machismo* is a traditional Hispanic value, specific to Mexican culture where men are expected to be hypermasculine and traits like stoicism, sexism, and heavy alcohol use are emphasized (Arciniega, Anderson, Tovar-Blank, & Tracey, 2008; Estrada & Jimenez, 2019).

Eight percent of the sample identified as transgender or nonbinary. For transgender or non-binary adolescents, studies have found difficulties accessing equitable and affirming care and these barriers to equitable care increase even more for transgender or nonbinary youth of color. The sample in the current study is consistent with prior studies in that there was a small number of transgender or non-binary patients available in the data set. However, a small number of transgender youth is consistent with population estimates. According to Herman et al. (2022), 1.43% of 13-17 year olds and 1.31% of 18-24 year olds identify as transgender in the United States. Our sample percentage being

slightly higher than population estimates may reflect the increased risk, severity of depressive symptoms, and the need to access care for transgender, non-binary, and gender non-conforming youth (Tordoff et al., 2022).

Interpretation of Results

The following sections will detail results of the analyses completed in the current study, how they align with the current literature, and implications for the study's findings.

Question 1. Research question 1: How did Hispanic adolescents respond to Behavioral Activation (BA) treatment as evidenced by changes in depressive symptoms and health-related quality of life from admission to discharge? In the study, adolescents' results indicated significant improvements in health-related quality of life and depressive symptom severity when comparing pre- to post- outcome scores following BA treatment. For the sample of adolescents overall, the current study's effect sizes for health-related quality of life and depressive symptoms were 0.98 and 1.07, respectively. These findings correspond with the results of a meta-analysis on BA for adolescents, in which researchers found BA to be effective for adolescents (Martin & Oliver, 2019). Morgan and colleagues (2021) similarly found improvements in depressive symptoms and health-related quality of life. However, a smaller number of Hispanic adolescents were included in the sample (n = 29). Collado et al. (2016) examined the effectiveness of BA among Hispanic adults who were Spanish-speaking and found improvements in depressive symptoms, as well as sustained gains during a 1-month follow-up. However, prior studies have not examined BA treatment's effect on health-related quality of life.

Behavioral health clinics used in this study provided manualized BA treatment, which included patients working alongside a behavioral health clinician who assisted the patient in identifying their personal values and goals. This is important to examine as adolescents' values may differ or be similar to traditional Latino/e cultural values and allows the clinician to better understand the patient's adherence

to traditional cultural values. Patients determined activation goals, or areas of their life to increase engagement. The clinician also helped the patient determine behaviors or actions aligned with their values and created an achievable plan to engage in routine, pleasant, and valued activities. This approach of incorporating one's individual values and environmental contexts may have increased the relevance of BA to the Hispanic patients being served. Studies prior have found psychotherapeutic interventions that are culturally sensitive and adapted to one's culture result in larger effect sizes (Hall et al., 2016).

Question 2. Research question 2: How satisfied were Hispanic adolescents with intensive BA treatment, both overall and as being sensitive to their cultural identity? The study also examined how satisfied Hispanic adolescents were with BA treatment, both overall and as being sensitive to their cultural identity. Findings indicated levels of satisfaction ranged from "more satisfied than dissatisfied" to "very satisfied" for the overall sample. For the first question examined on the Patient Satisfaction Survey asked patients to rate their "overall level of satisfaction with your care" with response options ranging from "very dissatisfied" to "very satisfied." The overall sample had a mean response of a 3.00 (*SD* = .90), which indicated a "very satisfied" level of satisfaction. When asked "How satisfied are you regarding staff's cultural sensitivity to your identity" the mean response from patients was a 3.47 (*SD* = .74), which also fell in the "very satisfied" range. When patients were grouped into the three adolescent age groups (e.g., early [11-14 years], middle [15-17 years], and late [18-21 years] adolescence), findings indicated that middle adolescents had a significantly higher satisfaction than late adolescents when asked to rate their "overall level of satisfaction with your care." However, when asked "How satisfied are you regarding staff's cultural sensitivity to your identity" there were not significant differences in how patients responded based on age group.

Prior research regarding patient satisfaction has found satisfaction with care increases with time spent in treatment and when aspects of heritage and culture are incorporated into care (Jones et al.,

2003, Collado et al., 2016). Recent studies have not examined patient satisfaction with care overall or patient satisfaction with providers' levels of cultural sensitivity as it relates to BA treatment for the adolescent population. An older study found patients of color reported lower quality and appropriateness of treatment, if aspects of their heritage and culture were not present in care provided by clinicians (Jones, 2003). In addition, Hispanic patients were more likely than White patients to report poorer quality of care (Institute of Medicine [IOM], 2002). Therefore, the findings for the current study are promising in that adolescent patients reported being satisfied with BA treatment following their care at the behavioral health clinics. Given the literature surrounding the effects of providers trainings in culturally sensitive approaches improving cultural awareness, communication, and understanding of patient's cultural experiences, these improvements may be linked to greater satisfaction with care (Mills et al., 2017).

Given the current literature on the importance of satisfaction with treatment as it relates to decreasing dropout and increasing engagement, these results are important in the consideration of BA as a treatment option for Hispanic adolescents with depressive symptoms. A prior study examined Hispanic, Spanish-speaking adults' satisfaction with BA treatment researchers and administered a researcher- developed measure they developed at sessions 2, 5, 8, and 10 (Collado et al., 2016). Researchers found satisfaction with treatment increased over time. In addition, there were no differences in satisfaction when comparing BA to supportive counseling.

Question 3. Research question 3: What is the relationship between treatment outcomes and satisfaction with care overall? This study also examined the relationship between changes in treatment outcomes and satisfaction with care overall. The findings did not demonstrate a significant relationship between depressive symptoms and satisfaction with care overall. This finding is unexpected in that greater satisfaction with treatment has been linked to increased compliance with treatment targets, which can improve pathology symptoms (Miglietta et al., 2018). In addition, prior investigations on the

relationship between collaborative care, depressive symptoms, and satisfaction with care overall found depressive symptom improvement, partially mediated the collaborative care model's effect on patient satisfaction (Deen et al., 2010). However, this study was done within primary care clinics using a collaborative care model and not specifically focused on Hispanic people or Hispanic adolescents.

Additionally, the study did not uncover a significant relationship between changes in health-related quality of life and satisfaction with care overall. Prior studies have not specifically examined the relationship between health-related quality of life and satisfaction with care overall within the context of behavioral healthcare. However, prior studies have investigated factors that may cause changes in satisfaction among late adolescents and adults (Constantine, 2002). Patients in this study indicated therapeutic alliance, clinician levels of multicultural competence, and empathy contributed to changes in their satisfaction with care (Constantine, 2002). Fortin (2018) found factors like continuity of care, support for social or daily needs, and assistance with finding a job contribute to satisfaction with care amongst adult populations. Given prior findings in the literature regarding the relationship between satisfaction with care and changes in outcomes the results of no significant association are unexpected.

Question 4. Research question 4: What is the relationship between treatment outcomes and satisfaction with providers' levels of cultural sensitivity? This study also examined the relationship between changes in treatment outcomes and satisfaction with providers' levels of cultural sensitivity.

The findings did not demonstrate a significant relationship between changes in depressive symptoms and patient satisfaction with providers' level of cultural sensitivity. This finding was not anticipated given the prior literature which has found greater satisfaction with treatment has been linked to increased compliance with treatment targets and greater compliance can improve symptoms (Miglietta et al., 2018). In addition, the current study found a significant, negative relationship between patient satisfaction with providers' level of cultural sensitivity and changes in health-related quality of

life. Researchers prior found satisfaction with care increased with time spent in treatment (Collado et al., 2016). Therefore, the findings regarding providers' level of cultural sensitivity and changes in health-related quality of life were not anticipated. Prior studies have compared effectiveness of treatments that were culturally adapted to treatments without cultural adaptations and found culturally adapted interventions tended to have larger effect sizes (Huey, 2013; Huey et al., 2014). The lack of significant association between changes in treatment outcomes and patient satisfaction with providers' level of cultural sensitivity may be due to the current study not utilizing direct adaptations to BA treatment. It should be noted that the data used in the study were collected from 2018-2023 and the allyship and belonginess training for providers began in January 2022. Therefore, some patients received treatment from providers who did not yet undergo the allyship and belongingness training. We cannot conclude that the findings related to satisfaction were the result of staff-focused training on allyship and belonginess. Therefore, findings regarding the relationship between patient's level of satisfaction with providers' level of cultural sensitivity and its relationship to treatment outcomes should be interpreted with caution.

To further understand these results, follow up analyses were conducted by age groups to better understand treatment outcomes across age groups, as evidenced by changes in depressive symptoms and health-related quality of life. Additionally, treatment satisfaction as it relates to overall care and providers' level of cultural sensitivity were also examined.

Follow Up Analyses By Age Group. Examinations of treatment effectiveness by age group were important to consider, as clinicians must deliver psychological interventions that are developmentally appropriate to the patients they serve. A treatment not being appropriate to the population can lessen effects and for younger adolescents, may call for more parental involvement in treatment. Our findings indicated that there were not significant differences in changes in depressive symptoms for the three adolescent age groups, but there were significant differences between groups in changes of quality of

life from pre- to post. More specifically, late adolescents had significantly greater changes in quality of life from pre to post when compared to middle adolescents and early adolescents. For the first question examined on the Patient Satisfaction Survey, which asked patients to rate their "overall level of satisfaction with your care," middle adolescents had a significantly higher satisfaction than late adolescents. For the second question examined which asked "How satisfied are you regarding staff's cultural sensitivity to your identity" there were not significant differences in how patients responded based on age group. A prior systematic review and meta-analysis by Cujipers and researchers (2020) examined psychotherapy outcomes for depressed patients across different age groups and included 366 studies. This study uncovered a difference in treatment outcomes between the adolescent (13-18 years) and young adult (18-24) age groups, as well as differences in treatment effects when comparing youth younger than 13 years old and all other age groups (Cuijpers et al., 2020). Youth younger than 11 years of age had smaller effect sizes (g = 0.35) than every other age group and adolescents (g = 0.55) had smaller effect sizes than young adults (g = 0.98). Differences in satisfaction with care were not examined in the Cujipers and researchers (2020) study or in the prior literature. However, these results differ from the current study in that there were not differences in Hispanic adolescents' changes in depressive symptoms between age groups.

Limitations

There are several limitations to the current study. The setting of this study was in behavioral health clinics throughout the United States who do not take Medicaid or the Children's Health Insurance Program (CHIP). Medicaid is a public health insurance program for people who are below poverty in the United States (Zhang & Wu, 2021). CHIP is a program for children who do not qualify for Medicaid but cannot afford private insurance (United States Department of Health and Human Services [HHS], 2017). Generally, about 48% of Hispanic children are insured through Medicaid and CHIP (Perreira et al., 2021). Therefore, socioeconomically, this sample may not fully reflect the population of Hispanic/Latinos in the

United States and may better represent Hispanic adolescents who come from families of a higher socioeconomic status. Research suggests patients who are uninsured, using Medicaid, or CHIP are more likely to seek care at Federally Qualified Health Centers, which include community health clinics, migrant health centers, healthcare for the homeless health centers, and public housing primary care centers (United States Department of Health and Human Services [HHS], 2017). Currently, Hispanic children and adolescents represent about 40 percent of all uninsured children in the United States (Alker & Corcoran, 2020).

Additionally, the current study was completed using archival data from the behavioral health clinics. Measures and questionnaires used were part of routine intake and discharge procedures. Therefore, additional measures could not be included in the current analyses. Other factors may have contributed to patient's compatibility with the treatment used, like language of the provider, their preferred language, generational status (i.e., first, second, or third generation) or levels of acculturation which were not assessed as part of routine intake or discharge procedures in the current study.

There were significant amounts of missing data on the Patient Satisfaction Survey questions, which may have impacted the results related to research questions (RQ) 2, 3 and 4: RQ #2) How satisfied were Hispanic adolescents with intensive BA treatment, both overall and as being sensitive to their cultural identity?, RQ #3) What is the relationship between treatment outcomes and satisfaction with care overall?, and RQ #4) What is the relationship between treatment outcomes and satisfaction with providers' levels of cultural sensitivity?

For question 10 on the Patient Satisfaction Survey, asking patients to rate their "overall level of satisfaction with your care," only 46% of patients completed the item (72 out of 155 total patients). For question 21 on the Patient Satisfaction Survey which asked patients to rate "How satisfied are you regarding staff's cultural sensitivity to your identity," only 40% of patients or 62 out of 155 patients

responded. The presence of the missing data reduced the total sample size, and therefore, the statistical power for these questions. Therefore, these conclusions should be interpreted with caution.

Finally, the Patient Satisfaction Survey was an internally developed survey, which is common for academic medical settings and outpatient providers who provide mental health care within the United States (Al-Abri & Al-Balushi, 2014). Using an internally developed survey allows providers to include important questions for the institution related to satisfaction. Developers also may import questions from other standardized measures. However, using a standardized measure allows for replications in future research, as well as having good reliability and validity. In addition, using a quantitative measure limited the additional qualitative and anecdotal information and patient explanations for their level of satisfaction from being collected.

Future Directions

Exploring Acculturation. Studies are beginning to examine how acculturation may affect health behaviors and satisfaction with care for Hispanic patients, but this is yet to be explored within behavioral healthcare (Oguz, 2019). Acculturation may be an important aspect to consider as it has been reported as a significant contributor to dissatisfaction with communication between physicians and their patients in medical settings among Hispanic adults (Oguz, 2019). Acculturation has been examined as it relates to treatment engagement among depressed, Spanish-speaking Hispanic patients (Santos et al., 2017). Researchers found the pressure to prefer traditional Latinx/e healing practices over psychotherapeutic interventions was an obstacle to treatment retention (Santos et al., 2017). Researchers have found acculturation may have benefits like awareness of health systems, reduced social isolation and alienation, more success at school and work (Koneru et al., 2007). This makes acculturation an important area to examine in the context of depressive symptoms, which are often

increased with isolation and less social engagement or belongingness (Martin & Oliver, 2019; Mojtabail, Olfson, & Han, 2016).

Patient Satisfaction and Treatment Outcomes in Community Health Settings. Given that Hispanic patients are more likely to seek care within Federally Qualified Health Centers (FQHC), specifically non-profit hospitals or community mental health centers, it is important to assess quality of care, effectiveness of BA, and patient satisfaction within these settings (Perreira et al., 2021). Community health settings are unique in that they typically have higher rates of staff turnover and burnout, which can impact the fidelity of intervention implementation, and continuity of care for patients (Woltman, 2008). Continuity of care is important because studies have shown that Hispanic patients are less likely to receive timely and consistent care when compared to their White counterparts (Oguz, 2019). Researchers have posited that community health centers have the highest probability to serve Hispanic patients who may be uninsured or insured through public health insurances, like CHIP (Rosalves & Calvo, 2019). According to Rosalves and Calvo (2019) Hispanic patients were least likely to receive services at public agencies and for-profit institutions. The behavioral health centers in the current study were for-profit institutions. This may explain the original dataset retrieved from the behavioral health clinics with 1,875 patients and 155 patients identifying as Hispanic (8% of the dataset).

Summary

The current study sought to examine the effectiveness of BA as it relates to health-related quality of life and depressive symptom severity in intensive mental health settings. The study found BA treatment significantly improved health-related quality of life and depressive symptoms as reported by Hispanic adolescents who underwent treatment at the behavioral health clinics. In addition, the study found that Hispanic adolescents ranged from “more satisfied than dissatisfied” to “very satisfied” with their care overall and as being sensitive to their cultural identity. When the relationship between

treatment satisfaction and treatment outcomes were examined, researchers found satisfaction with care overall was not correlated with changes in depressive symptom severity or health-related quality of life. When the relationship between treatment outcomes and satisfaction with care as it relates to provider's level of cultural sensitivity was examined researchers found that satisfaction with care as it relates to provider's level of cultural sensitivity was negatively correlated with changes in health-related quality of life. Results regarding patient satisfaction and the relationship between satisfaction with care and treatment outcomes should be considered with caution given the large amount of missing data, as well as data collection procedures, which may have resulted in higher ratings on the patient satisfaction measure. Subgroup analyses were completed for the three adolescent age groups (e.g., early [11-14 years], middle [15-17 years], and late [18-21 years] adolescence). Findings revealed those in the late adolescence age group had significantly greater changes in quality of life from pre to post when compared to those in the middle and early adolescent age groups. Further, middle adolescents had a significantly higher satisfaction ratings than late adolescents when rating their "overall level of satisfaction with your care". Further research should be conducted in community health settings and explore factors like acculturation to examine how they affect treatment outcomes.

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