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Barriers to and Facilitators of Mental Health Treatment Engagement among Latina Adolescents

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Abstract

Latina adolescents are more likely to experience depressive symptoms and less likely to receive mental health treatment than White peers. The purpose of this study is to describe barriers to and facilitators of engagement in depression treatment among Latina adolescents. Twenty-five Latina young women (mean age=16.7 years) with a history of depressive symptoms during adolescence participated in this qualitative descriptive study. Participants were recruited from clinical and community settings and were interviewed about their experiences with depression treatment. Using qualitative content analysis, we identified barriers to and facilitators of engagement in treatment for depression. Barriers included beliefs about depression and its treatments, negative experiences with treatment, and logistical problems. Facilitators included positive treatment outcomes, meaningful connection with a therapist, and family support of depression treatment. Mental health providers should minimize barriers and maximize facilitators to promote mental health treatment use and engagement among Latina adolescents with depressive symptoms.

Keywords

Hispanic Americans; adolescent; depression; mental health services

Introduction

Latina (female) adolescents are more likely to experience depressive symptoms than their White, Black, and Latino (male) peers (Centers for Disease Control and Prevention, 2018) as well as show significant disparities in the utilization of mental health treatments. In 2016, the Substance Abuse and Mental Health Services Administration's (SAMHSA) national survey revealed that 31% of Latina adolescents received treatment for an episode of major depressive disorder in comparison to 41% of White adolescent girls (SAMHSA, 2017). Both male and female Latino/a adolescents are less likely than White peers to receive treatments from a formal mental health provider (Garland et al., 2005) or be prescribed antidepressant medication (Cummings & Druss, 2011; Kirby, Hudson, & Miller, 2010). Although research has established that experiencing cultural stressors contributes to the development of the

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high rates of depressive symptoms among this population (Authors, in press), much less research has focused on exploring reasons for the underutilization of treatments for depression among Latina adolescents.

Researchers have discovered many barriers to engagement in depression treatment among the Latino/a population in general. Treatment engagement can refer to both behavioral (ex. initiating treatment, retention in treatment) and attitudinal factors (ex. investment in treatment, commitment to treatment; Lindsey et al., 2014). Stigma towards depression is one of the most commonly discussed barriers to treatment engagement in Latino/a adult populations (Cabassa, Hansen, Palinkas, & Ell, 2008; Green et al., 2017; Interian, Martinez, Guarnaccia, Vega, & Escobar, 2007; Pincay & Guarnaccia, 2007; Uebelacker et al., 2012). Latino/a adults fear being labeled as *loco/a* (crazy; Cabassa et al., 2008; Interian et al., 2007; Pincay & Guarnaccia, 2007) or burdening their families (Martinez, 2017; Uebelacker et al., 2012) if they were to seek out mental health treatments. Several researchers have also documented a common belief among Latino/a adults that antidepressants are addictive, which serves as a barrier to initiating pharmacologic treatment (Cabassa et al., 2008; Green et al., 2017; Interian et al., 2007; Pincay & Guarnaccia, 2007; Uebelacker et al., 2012). Some Latino/a adults have also noted that they lack knowledge about available treatments for depression or even about depression itself, preventing them from seeking treatment (Barrio et al., 2008; Pincay & Guarnaccia, 2007; Uebelacker et al., 2012). Others have felt that healthcare providers have a cold demeanor and do not strive to create a trusting relationship with their patients (Martinez, 2017; Pincay & Guarnaccia, 2007). Additional barriers to engagement in treatment for depression include inability to afford treatment (Pincay & Guarnaccia, 2007; Uebelacker et al., 2012), lack of transportation to appointments (Barrio et al., 2008; Pincay & Guarnaccia, 2007), and absence of linguistic and culturally appropriate care (Barrio et al., 2008; Uebelacker et al., 2012). In contrast to these barriers, researchers have noted that the formation of a warm, caring relationship with providers facilitates engagement in treatment for Latino/a adults who are depressed (Cabassa et al., 2008; Pincay & Guarnaccia, 2007; Uebelacker et al., 2012).

While several studies have explored barriers to and facilitators of treatment engagement in Latino/a adults, only a few have explored these topics among Latino/a adolescents. In a series of focus groups with Latino/a middle and high school students, Fornos et al. (2005) found that cost and distrust of mental health professionals were perceived barriers to treatment engagement for Latino/a adolescents with depression, similar to what has been observed in Latino/a adult populations. Unlike what has been noted in the adult literature, however, Fornos et al. (2005) found that concerns about confidentiality being broken by mental health professionals prevented Latino/a youth with depression from seeking mental health treatments. Similarly, in mixed samples including both Black and Latino/a adolescents, stigma towards depression and concerns about confidentiality were noted as barriers to treatment engagement (Ijadi-Maghsoodi et al., 2018; Schneider, 2017). Facilitators of treatment engagement in these groups were similar to those noted in Latino/a adult populations and primarily included the establishment of a personal connection with a mental health provider (Ijadi-Maghsoodi et al., 2018; Schneider, 2017). Other facilitators not addressed in the adult literature included unique therapy approaches (Schneider, 2017) and gaining a new perspective from mental health treatment (Fornos et al., 2005). While these

studies have noted a few barriers to and facilitators of treatment engagement in Latino/a adolescent populations, no studies to our knowledge have explicitly examined barriers to and facilitators of treatment engagement specifically among Latina adolescents with depression.

Given the high rate of depressive symptoms and low rate of mental health treatment use among this population, a greater understanding of Latina adolescents' experiences with treatment engagement is needed to inform the development of culturally sensitive treatment strategies that will promote engagement in treatment for depression. The purpose of this study is to identify barriers to and facilitators of treatment engagement in a sample of Latina young women who experienced depressive symptoms during their adolescent years.

Methods

Parent Study

The data used in this study are derived from a larger qualitative study exploring how depressive symptoms, self-management, and treatment seeking unfold over time for Latina young women who experienced depressive symptoms during adolescence. Twenty-five young Latinas (ages 12-20) living in a metropolitan city in the Midwest participated in the study. For qualitative studies examining a shared psychosocial phenomenon, Morse (2000) recommends 20 to 30 participants to achieve a sufficient sample size, indicating that our sample of 25 young women was appropriate for this study. Inclusion criteria for all participants were: 1) Self-identification as Hispanic or Latina; 2) self-identification as female; 3) fluency in English; 4) self-report of depressive symptoms during adolescence; and 5) 13-21 years of age. Participants were recruited from both community and clinical settings in order to ensure a sample with a variety of treatment experiences or with no formal treatment experiences at all. Adolescent and young adult Latinas with a documented clinical history of depression were recruited from a primary care clinic that served a large Latino/a population. Adolescent and young adult Latinas from the community, who may or may not have had treatment, were recruited with fliers that were placed in community settings likely to be frequented by Latina young women. Exclusion criteria included the following: 1) Imminent thoughts of self-harm, or 2) significant mental distress.

The team obtained parental consent and adolescent assent for adolescent participants (ages 13 to 17) and informed consent for young adult participants (ages 18 to 20). Participants completed a short demographic questionnaire prior to the interview. Semi-structured interviews driven by an interview guide were conducted to gather the qualitative data. In the case that a participant became distressed or expressed safety concerns during the interview, a distress protocol was used to guide the response of the interviewer (Authors, 2009). At the conclusion of the interview, the participant was compensated with a $30 gift card. All study procedures were approved by the Indiana University Institutional Review Board. Additionally, the authors have no conflicts of interest to disclose relevant to this study and are responsible for the content of the manuscript.

Interviews were conducted in community locations with available private rooms. They were audio-recorded and typically lasted one hour. The interviews followed a funnel approach in which they began with general questions concerning overall experiences with depressive

symptoms and transitioned to focused questions to collect other important information related to the study aims. For instance, the interview guide included general questions about participants' help-seeking experiences for depressive symptoms and then focused on each help-seeking experience in particular. The information about seeking and obtaining mental health treatment for depression was used for analysis in the current study.

Current Study

A qualitative descriptive design (Sandelowski, 2000) was employed in the current study. This method is used when a low-inference representation of a phenomenon is desired. The research team chose a qualitative descriptive design in order to obtain a straightforward depiction of the common barriers to and facilitators of treatment engagement among Latina adolescents with depressive symptoms.

Qualitative content analysis, the typical method of data analysis in qualitative descriptive studies (Sandelowski, 2000), was used to analyze the data (Miles, Huberman, & Saldana, 2014). Both authors began the analysis by reading all transcripts in their entirety with a particular focus on how Latina young women described their treatment experiences. The first author completed initial coding of all transcripts using Microsoft Word® (Charmaz, 2014). Any initial codes related to mental health treatment use were copied into a content analytic summary table (Miles et al., 2014). This table is a type of data matrix that brings together all textual data related to a specific phenomenon into a single display to facilitate the identification of commonalities across all participants (Miles et al., 2014). Data were then separated into two broad topics: barriers to treatment engagement and facilitators of treatment engagement. Within each topic, the first author grouped similar codes together into potential categories and then labeled and defined the categories. The authors met on a weekly basis to discuss the emerging categories. If disagreements between the authors arose regarding how the codes were categorized, labeled, or defined, discussion and re-examination of the data were used to reach consensus. The first author wrote a narrative summary of each category that represented a barrier to or facilitator of depression treatment engagement; the summaries were then verified by the second author. The first author also maintained an audit trail through writing analytic memos to track all analytic decisions (Charmaz, 2014). The barriers and facilitators are described below.

Results

Twenty-five Latina young women participated in the study. Participants were on average 16.7 years of age, ranging from 13-20 years old. The majority of participants were of Mexican ethnicity (n=16; 64%). Participants also identified as Puerto Rican (n=3), Salvadoran (n=3), Colombian (n=1), Nicaraguan (n=1), Venezuelan (n=1), Honduran (n=1), Tejano (n=1), and Cuban (n=1). Three participants described themselves as having more than one ethnicity. First-generation immigrants or individuals born on the island of Puerto Rico composed nearly one third of the sample (n=8). These participants had lived an average of 10 years in the mainland United States.

Second-generation participants composed approximately two-thirds of the sample (n=15). One third-generation and one fourth-generation immigrant also participated.

The majority of participants described having received some form of mental health treatment (n=16). Of these sixteen participants, ten had been prescribed medication for their depression, and sixteen had been referred to psychotherapy. Eight participants had had inpatient hospitalizations primarily for suicidality. While a few participants described positive and consistent treatment engagement, most of the participants were not well engaged in treatment. Some never initiated treatment for their depressive symptoms or were not retained in treatment for long. Others had low investment or commitment to treatment. For example, individuals commonly lied to mental health providers to get out of treatment sooner.

Barriers to Treatment Engagement

Participants described a number of barriers to treatment engagement. These barriers include particular beliefs about depression and mental health treatment, negative experiences with treatment, and logistical problems.

Beliefs about depression.—Fourteen participants and/or their families held beliefs that contributed to poor treatment engagement. These beliefs were that depression is not "real," a sign of weakness, or immaturity.

Depression is not real.: To many participants and their families, depression was not a "real thing" but rather a problem that individuals make up in the absence of actual challenges in their lives. Several participants attributed this belief to their families having faced so many dire struggles in their home countries and during immigration. One participant's parents had said, "'You have so many things, why are you going to be sad? There's no such thing as depression." … People in other countries, they don't even have clean water… people in America, they don't know what real problems look like." Other participants were told that depression was a "White person problem." One participant remarked, "If you expressed you're depressed or cutting or angry about life to them [parents], they think it's White people stuff. It's not a problem here."

Depression is a weakness.: Several participants' family members asserted that depression signified that a person was "weak" and could not deal with life's challenges. Participants thus often hid their depression from others because they wanted to appear "strong." They also linked this belief to their families' history of immigration. In reflecting on her grandmother's life in immigrating to the U.S., one participant recounted:

> You're just like, "Wow, they're [grandmother] so strong." They're just so strong, and they've been through this, and they just went through it…they didn't cry about it…It's definitely something that you just kind of just took it, and you just put it on your back and said, "I'm going with it." If they can do whatever, I can do this.

Depression is immaturity.: Participants also received messages from others that depression was just a young person's way of acting out or seeking attention. If the participants shared their depressive symptoms, they were told that they were "too sensitive," "trying to get attention," "over-dramatic," or having "tantrums" or that their symptoms were just part of adolescence. One participant said, "I definitely feel that sentiment of like, 'Oh, they're just a

teenage girl' from my parents. They often complain about, 'Oh adolescence is so hard' in a way that demeaned me." A few participants were punished when they tried to get help for their depressive symptoms because parents viewed it as "acting out." One participant revealed that her parents said, "'You're just acting out because you want attention type stuff.'" They also said, "'If you don't lie to these people [school counselors] about your depression, you're in punishment'." The participant concluded that depression was not taken seriously in her culture.

Beliefs about mental health treatments.—In addition to beliefs about depression, seven participants and/or their families held beliefs about mental health treatment that contributed to poor treatment engagement. These beliefs are that young people should not take medication and that therapy is not useful.

Young people shouldn't take medications.: Several participants and their family members believed that using medications to treat depression was harmful to young people. A few participants feared that they would become addicted to antidepressant medications and need to take them for the rest of their lives. Others heard that antidepressants might increase their risk of suicide, which made their family members weary of medication. One participant stated, "They [doctors] also said that it [antidepressants] could increase suicidal thoughts and stuff like that, and my mom didn't want me to take them… which I was pretty upset with her, because I felt like it would help me feel better."

Therapy is not useful.: Several participants did not believe that mental health treatment would help them. They thought that while it might benefit some people, it would be a "waste of time" for them. One participant said, "I just didn't really believe in them [therapists]. What could a… therapist do that I can't do? I ended up not doing any of that [going to therapy]."

Negative experiences with treatment.—Thirteen participants had negative experiences with mental health treatment that contributed to poor treatment engagement. These experiences included unhelpful treatment approaches, medication side effects, distrust of a mental health provider, and terrifying hospital experiences.

Unhelpful treatment approach.: Many participants balked at the therapeutic approach used in their treatment and found it to be unhelpful, especially if it involved just discussing their problems. The participants found treatments to be "awkward," "uncomfortable," or even "nonsense-based." One participant claimed, "She [therapist] tended to just agree with everything I said, and, maybe that works for some people, but I wanted more suggestions from her. I just don't think the way she approached me was the best way for me."

Medication side effects.: Several participants who had been prescribed antidepressant medications abruptly stopped taking their medications due to unpleasant side effects. They felt the medications made them feel "drained," "blank," and "zoned out." One participant described her thoughts about medication:

> It [medication] just sounded sketchy. The way my psychologist described it… it suppressed the things that made you want to cut. That's so sketchy. There's not a certain thing that makes you want to cut. That's so iffy, and I was reading about it, and I was like I don't want to take this. It makes me nauseous. I don't like this. It's not really doing anything for me, so I stopped that [taking medication].

Distrust of a mental health provider.: Many participants were unable to form a meaningful connection with their mental health provider due to concerns about trust. Some participants did not trust their providers because of the provider's personality. Participants described providers as being "strangers," "awkward," or "too short" with them. Some participants felt that therapists treated them like they were "crazy" or a "psychopath." One participant stated, "When you say you have mental health problems, they stop talking to you like you're a person, and they talk to you like you don't have any control over your mind." Other participants believed that their mental health provider had violated their confidentiality. One participant stated, "But because I'm a minor I guess she was forced to tell my parents that I was having issues… Well what's the point in seeking help when I'm still a minor, and no matter who I go to they have to report it to my parents?"

Terrifying hospital experiences.: Several participants were hospitalized, mostly for suicidal ideation or attempts, and generally found this experience to be "scary," "terrifying," and "traumatizing." They were often placed with other patients who were experiencing serious mental illness, and some witnessed frightening events. One participant said, "I went to the hospital, and that was one of the scariest times of my life. I thought I was going to die. There was like a naked woman walking around screaming… I don't want to be here." Participants also felt like they were "trapped" on inpatient units and were not told when they were going to be released to go home.

Logistical problems.—Eight participants had practical problems that contributed to poor treatment engagement. These problems included therapist unavailability and financial constraints.

Therapist unavailability.: A few participants had difficulty finding a therapist for on-going treatment. One participant described that the therapist in the primary care clinic where she was obtaining treatment was never available on the day of her clinic visits. Others had to switch therapists due to their retirement or switching practices. One participant explained, "She [therapist] was also retiring from her job, while she was talking to me and stuff, so that's why I had to move to a new therapist which didn't help at all."

Financial constraints.: For several participants, the cost of treatment was a barrier to help-seeking. Some found that treatment was too "pricey" or not covered by their insurance. One stated, "She [doctor] assigned me to talk with a counselor, and we're still figuring that out, because with my family, we can't just go spending money on different types of people."

Facilitators of Treatment Engagement

Although participants encountered numerous barriers to treatment engagement, some participants described facilitators of engagement. The facilitators include positive treatment outcomes, a meaningful connection with a therapist, and family support for mental health treatment.

Positive treatment outcomes.—Fourteen participants described positive outcomes that promoted treatment engagement. These outcomes included a new perspective and new tools for dealing with everyday problems.

A new perspective.: Through therapy, participants gained insight that changed their views of themselves or their lives. They stated that they obtained "acceptance," "forgiveness," and a "new perspective." One participant described what she heard from her therapist: "'It's not you. Nothing's wrong with you. You're not producing a chemical. You're not weak or anything. I just need you to recognize…what you've been through. It's okay to feel that way.' It was an eye opener."

New "tools" for dealing with problems.: In treatment, some participants learned helpful strategies for managing their everyday problems. They learned breathing and meditation techniques to manage stress, goal-setting skills to get their lives on track, and healthy communication to alleviate interpersonal problems. One participant described how helpful it was to learn such strategies:

> She [therapist] told me a very good coping skill when you're stressed out was to practice your breathing. She gave me bubbles, and she said try to make them as big as possible when you're breathing…Even when I'm stressed out, I still remember about that. I still kind of like remember her in that way that she's the person who specifically taught me how to deal with my stress.

Meaningful connection with a therapist.—Six participants developed a sustained meaningful connection with a mental health provider, which promoted treatment engagement. Providers who were caring displayed small acts of kindness, took a personal interest in the participants, and were kind and "inviting." A meaningful connection also depended on trust. Participants wanted to be free to openly share information with their therapist without fear of judgement or confidentiality being broken. One participant described her close and trusting relationship with her therapist:

> She was mine in a sense… She wasn't my mother, and she gossip it to my *tía.* Or she wasn't my sister, and she would just pat me on the back and say it's okay. She was just mine. She didn't know my grandmother. She didn't know my mom…. she didn't know all my friends that I was talking about, which was really nice.

Family support for mental health treatment.—For five participants, depression was recognized as a serious problem by the family. As a result, the family was supportive of the participants receiving mental health treatment, and this promoted treatment engagement. One participant stated, "My parents, I think they already knew me because they're my

parents. They took me seriously when I said I was sick [with depression].” In some cases, the participant’s parent had a history of depression, and therefore understood how devastating it could be. One participant said, “My mom has depression, and she didn’t want us [brother and I] to go through that because she has medicine for depression. And that’s why she moved pretty fast [getting us into therapy], because she knows how bad it is.”

Discussion

Latina adolescents in the current study who experienced depressive symptoms described a number of barriers to and facilitators of engagement in mental health treatment, although they experienced more barriers than facilitators. While many of the participants and/or their families held beliefs about depression and mental health treatment that impeded engagement, if families took depression seriously and were supportive of adolescents seeking treatment, adolescents were more likely to be engaged in treatment. Once Latina adolescents had sought mental health treatment, negative experiences with treatments or therapists could turn participants away from treatment, but positive experiences with therapy and mental health providers promoted better treatment retention and commitment.

Several of the barriers to engagement described by the Latina adolescents in our study have been observed in previous research. Similar to our participants, adolescents of diverse backgrounds have reported fear of judgement and concerns about having their confidentiality broken by mental health providers (Authors, 2005; Ijadi-Maghsoodi et al., 2018). In other research, Latino/a adults described hiding their depression because they did not want to be perceived as making up problems (Martinez, 2017), a belief described by our participants as well. Several studies have found that Latinos/as have concerns that antidepressants are addictive (Cabassa et al., 2008; Interian et al., 2007; Martinez, 2017; Pincay & Guarnaccia, 2007; Uebelacker et al., 2012), a belief that was also endorsed by participants in our study. Similar to our participants, Latino/a adults in other studies also had concerns about trustworthiness of mental health providers (Martinez, 2017; Pincay & Guarnaccia, 2007). Participants in our study discussed the cost of mental health treatment, difficulties scheduling appointments, and mental health provider attrition as barriers, which have also been noted in prior research (Schnieder, 2017; Uebelacker et al., 2012).

The findings of our study also support previous research on facilitators of treatment engagement in Latino/a adults and general adolescent populations with depression. For example, our participants described the importance of having a caring mental health provider, which has been widely echoed in the literature as an important facilitator of engagement for both Latino/a adults (Cabassa et al., 2008; Pincay & Guarnaccia, 2007; Uebelacker et al., 2012) and adolescents in general (Ijadi-Maghsoodi et al., 2018; Schneider, 2017). Similar to the adolescents in our study, some Latino/a adolescents in the study by Fornos et al. (2005) described how mental health treatment changed their life perspective. Likewise, Schneider (2017) observed that Black and Latino/a adolescents enjoyed mental health treatment when the therapist gave them actionable advice (Schneider, 2017). Other research has also demonstrated that when parents perceive their children’s mental health problem to be serious, they are more likely to seek mental health treatment for their children (Reardon et al., 2017), similar to what was described by participants in our study.

Our study extends the findings of previous research on this topic in several ways. The current study was the first to specifically examine barriers to and facilitators of depression treatment engagement in Latina adolescents, a population in which depressive symptoms are high and mental health treatment use is low. Several of the negative beliefs that participants described have not been documented in previous research. In particular, the beliefs that depression is not a real problem within the context of an immigrant family and is something that immature, female adolescents make up for attention. Participants connected these beliefs about depression to fears about confidentiality being broken by their mental health providers. Participants were very weary of seeking mental health treatment and confiding in providers because they perceived that their family members would be upset or judge them if they were to find out they had depression. Unlike previous research (Barrio et al., 2008; Uebelacker et al., 2012), the participants in our study did not describe concerns about linguistic or cultural congruency between themselves and mental health providers as barriers to being engaged in treatment.

Limitations

The current study has several limitations. Participants self-selected to participate in the study based on a history of self-reported depressive symptoms. Since we did not conduct retrospective diagnostic interviews, some participants may have had sub-syndromal levels of depressive symptoms in which case certain mental health treatments might not have been indicated. Despite this limitation, many participants had been diagnosed with a depressive disorder and had received mental health treatment for depression. We also did not collect detailed information about the types of psychotherapy or medications that participants received. We included young adult participants in the sample so that they could reflect back on their history with depression treatment during the entirety of their adolescent years; however, their recall of events may have been limited by the passage of time. We did not include any non-English speaking participants in the sample, and these adolescents would have likely encountered some different barriers to treatment engagement than those in the sample. We also recognize that the Latino/a culture is not homogenous, so our examination of Latinas as a whole prevents us from making any conclusions about barriers to and facilitators of engagement in depression treatment for Latinas of various ethnic sub-groups.

Implications

Future studies should follow Latina adolescents who have been diagnosed with depressive disorders to determine what factors are associated with treatment engagement and positive mental health outcomes over time. Diverse samples of Latina adolescents of various language, ethnic, geographic, and generational backgrounds should be engaged in this research to further elucidate how demographic factors might impact engagement in depression treatment. This information, in combination with findings of previous research, can then be used to inform the development and testing of culturally-sensitive interventions to promote engagement in depression treatment among Latina adolescents.

In practice, mental health providers should minimize the barriers that Latina adolescents face when seeking mental health treatment. Providers should provide psychoeducation to Latina adolescents and family members about the etiology of depression and antidepressant

medications to target beliefs about depression and its treatments that might serve as barriers to treatment engagement. To further address stigma, providers should also use language that normalizes the stress that adolescents experience and emphasize how common mental health disorders are among US adolescents. Providers can also discuss potential stigma surrounding depression for adolescents growing up in immigrant families. To prevent negative treatment experiences, mental health providers should set clear expectations about confidentiality and allow the adolescent to have control over the disclosure process as appropriate if confidentiality must be broken. To target logistical barriers, providers should be knowledgeable of free or low-cost mental health resources in the community to minimize barriers associated with cost.

To promote Latina adolescents' engagement in treatment for depression, mental health providers should maximize known facilitators of treatment engagement. Since Latino/a individuals often perceive mental health providers as being cold, providers should seek to form meaningful and personal relationships with their clients, drawing on the Latino/a cultural value of *personalismo* (Davidson, Soltis, Albia, de Arellano, & Ruggiero, 2015). Mental health providers can also give adolescents practical advice and tools for managing their emotions that they are able to easily employ in their daily lives. Additionally, implementing mental health education programs within Latino/a communities may increase perceived severity of depression and knowledge of treatment resources, leading more Latino/a families to seek necessary mental health treatment for their adolescents.

While Latina adolescents are more likely to experience depressive symptoms than White adolescents, they are less likely to receive mental health treatment for depression than their White peers. Adolescents in the current study described how cultural beliefs about depression and its treatments, negative experiences with depression treatment, and logistical barriers in obtaining treatment were barriers to seeking or being fully engaged in depression treatment. However, Latina adolescents who were able to gain helpful tools in therapy, make a meaningful connection with a therapist, or have depression treatment prioritized by their family members were more engaged in treatment. Through minimizing barriers and maximizing facilitators, mental health providers can assist in making mental health treatments more appealing and accessible to Latina adolescents and contribute to minimizing the mental health disparities this population faces.

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