PREVALENCE OF AND ATTITUDES TOWARD DEPRESSION AMONG
FILIPINO AMERICAN WOMEN

By
Valerie Mae Kading

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STATEMENT BY AUTHOR

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This thesis has been approved on the date shown below:

______________________________        ________________
Judith A. Berg, PhD, RNC, WHNP, FAANP    Date
Associate Professor of Nursing
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ABSTRACT

Approximately 12% of American women are affected by a depressive disorder annually. Filipinos are the second largest subgroup of Asian Americans comprising of 18% of all Asian Americans, however, little research is available on their mental health status. Previous studies have indicated that Asian Americans underutilize mental health services and are reluctant to seek mental health services due to shame and stigma. The purpose of this descriptive study is to determine the prevalence of depression and attitudes toward depression among a sample of 35 Filipino American women. The Bio-psychosocial-Cultural Model guided the exploration of the relationship among culture, prevalence of depression, and attitudes toward depression. The Women’s Health Questionnaire (WHQ) was used to obtain demographic data. The Center for Epidemiological Studies Depression Scale (CES-D) was used to determine the prevalence of depression and the Beliefs about Depression and Anti-depressive Behavior (BDAB) questionnaire was used to determine the participants’ beliefs about depression. Descriptive statistics was used to analyze the demographic variables, CES-D and BDAB questionnaires. Pearson’s Product Moment Correlation was used to analyze the relationship between total CES-D score and responses to the BDAB questionnaire. The sample consisted of 35 self-identified Filipino American women. The mean age was 39.2 ± 9.5 years. The results indicated that 34.6% of the sample scored in the depressed range. The mean CES-D score was 14 ± 12.1. Most women believed statements reflecting self-help when depressed, and statements stating that it is more helpful to talk about depression with a friend or family member, rather than a doctor, to be true. There was a
significant positive relationship between total CES-D score and Statement 2 ($r=0.422$, $p=0.01$) and 8 ($r=0.366$, $p=0.031$). There was a strong positive correlation between total CES-D score and Statement 16 ($r=0.527$, $p=0.001$). Implications for nursing practice include appropriate depression screening among Filipino women, the provision of culturally competent care and providing education regarding depression and its causes to this population. This study provides baseline data for this understudied group and illustrates the views toward depression and treatment among this group of Filipino women.
CHAPTER ONE

Introduction

Chapter One presents the background, statement of the problem, purpose, and significance of the study. Demographics and research questions will also be presented.

Problem

More than 18 million American adults have a depressive disorder. In 1997, more than 30,000 individuals died from suicide and most had a diagnosis of depressive disorder or substance use disorder. The World Health Organization’s Global Burden of Disease study (1989) concluded that depression is a significant and debilitating worldwide health problem. Depression ranked 4th among all diseases and the WHO predicts that by 2020, depression will rank second after heart disease, comprising up to 15% of the disease burden in the world (Murray & Lopez, 1996). People who have a depressive disorder exhibit severe limitations in physical and social abilities that are significantly worse for patients with chronic illnesses including hypertension, coronary heart disease, and back problems (Wells et al., 1989).

Approximately 12% of American women or 12.4 million women are affected by a depressive disorder. In fact, women are affected by depression more than twice as often as men every year (National Institute on Mental Health, 2000). Women between the ages of 25 and 44 years are most frequently affected by depression.

Filipinos are the second largest subgroup of Asian Americans and it is expected that this population will double in the next 25 years (U.S. Department of Health and Human Services, 2003). Filipinos residing in the United States total 1,850,314 or
approximately 18% of all Asian Americans (U.S. Census Bureau, 2000), yet, little research is available on their mental health status. Filipino American women, in particular, have not been studied (Yu and Liu, 1992) and little is known about how depression affects them.

Several studies indicate that Asian Americans underutilize mental health services. In addition, the Asian Americans who utilize these services are more severely ill than their Caucasian counterparts (Durvasula & Sue, 1996; Sue & Sue, 1974). It has been speculated that Asian Americans are reluctant to use mental health services, therefore, when they seek these services, they are severely ill and the delay in seeking mental health services is attributed to shame and stigma (Okazaki, 2000).

**Significance**

The findings of the proposed study build on the scarce literature devoted to Filipino American women. Understanding how depression is viewed by this population will assist mental health professionals in screening for mental illness and providing culturally competent care to this Asian subgroup. Knowledge of attitudes toward depression will allow primary care providers, especially advanced practice nurses, to recognize and treat depression among this group.

**Research Purpose and Questions**

This study used a descriptive design to determine the prevalence of depression and attitudes toward depression among a sample of Filipino American women. The research questions were:
1. What is the prevalence of depression in a sample of Filipino American women?

2. What are the attitudes of Filipino American women toward depression and treatment?

3. Is there a relationship between Center for Epidemiological Studies Depression Scale (CES-D) score and attitudes of Filipino American women?

**Definitions**

*Filipina:* Pronoun used to describe the female Filipino.

*Filipino-American:* A person with Filipino ethnic background currently living in the United States.

*Depression:* A score of greater or equal to 16 on the Center for Epidemiological Studies Depression Scale (CES-D).

**Summary**

Chapter One stated the problem, significance, and research questions which guided this research. The purpose of this study was to determine the prevalence of depression and attitudes toward depression in a sample of Filipino American women. This study provided data that can encourage health care providers, especially advanced practice nurses, to screen for depression among Filipinas and also assist them in providing culturally competent care. Chapter Two will include the theoretical framework for the study and literature review.
CHAPTER TWO

Theoretical Framework

Chapter Two will detail the theory upon which the study is based. It will also provide a discussion of relevant literature.

*Conceptual Framework*

The Bio-Psychosocial-Cultural Model (Lee et al., 1994) will guide this study in the exploration of the relationship among culture, prevalence of depression, and attitudes toward depression. This model illustrates biological, psychosocial, and cultural dimensions that interact with each other to produce a life experience and response to life experience (see figure 1). This model has been used to explain the perimenopausal experience of midlife Filipina women (Berg, 1999).

This study will primarily focus on the psychosocial and cultural dimensions of the Filipino American women studied. The Psychosocial dimension includes the following variables: prevalence of depression and attitudes toward depression. The Cultural dimension includes the self-identity as Filipina.

![Figure 1. Bio-Psychosocial-Cultural Model (Lee et al., 1994)](image-url)
Review of Literature

This section describes and summarizes known data on depression and Filipino women plus their attitudes toward depression and treatment. Strengths and limitations of each study will also be described.

*Mental Health Issues among Filipino American Women*

*Prevalence of Depression*

Thompson and colleagues (2002) described the prevalence and potential predictors of psychological distress in a sample of 487 Filipinas living in Queensland, Australia. The Australian Longitudinal Study on Women’s Health and General Health Questionnaire (GHQ-28) was used to collect demographic information and answer their research questions. The results of the study indicated that the level of mental distress is slightly higher (23%, n=112) than the Australian general population but lower than other migrant groups such as Chinese and Vietnamese.

This large sample study provided data on a poorly researched Asian subgroup. In addition, the study was conducted over one year and data were collected at baseline and follow up one year later. This allowed for measurement of psychological distress over time, although no intervention was provided.

Although this research is valuable in adding to the small database on Filipinos, the sample consists of Australian Filipinas and may not be applicable to Filipina Americans. The study lacked information on whether the participants would meet criteria for clinical depression or other mental illness. Further, the researchers failed to define the term
mental distress and the researchers did not state the inclusion criteria for their participants.

Berg (1999) described the perimenopausal transition of 165 midlife Filipino American women. The prevalence of depression was measured by the CES-D. Despite high scores on marital relationship satisfaction and positive feelings toward menopause and aging, 24.8% (n=41) of the participants scored \( \geq 16 \) on the CES-D, which placed them into the depressed range. These results raise questions regarding the relationship between depression and cultural influences. Berg posits that the high prevalence of depression may be due to instrumentation problems often exacerbated among immigrants whose second language is English. The results contributed to current data on Filipino American women but furthered the need for additional research specific to depression in this population.

Miller and Chandler (2002) described acculturation, resilience and depression in 200 midlife women from the former Soviet Union. The CES-D was used to describe depression among this sample. The majority of the sample (84%, \( n=168 \)) scored 16 or higher. The results showed a mean CES-D score (28.3) that was 20 points higher and fell into the depressed range than a previously studied American sample of 2,514 adults (Radloff, 1977). In addition, results suggested the age at interview had a linear relationship with CES-D score, as age increased, the CES-D score also increased. Women who reported greater impact and demand from immigration also had higher CES-D scores. Lower CES-D scores correlated with women who reported greater fluency in English. Although these data are helpful in describing immigrant women, it cannot be
applied specifically to Filipino American women. Previous work with Filipinas noted their English language proficiency (Berg, 1999). The stressors incurred by European immigrant women may be unique to that group and cannot be generalized to Asian American women.

Takeuchi et al’s (1998) Chinese American Psychiatric Epidemiological Study studied and interviewed 1,747 Chinese Americans. Each participant was chosen from one household and was interviewed to determine lifetime prevalence of major depression and dysthymic disorder, which is defined as having chronically depressed mood for most of day for at least 2 years (American Psychiatric Association, 2000). Using the Composite International Diagnostic Interview a lifetime rate of 6.9% (n=120) for major depression was found; 3.4% (n=59) had a major depressive episode in the past 12 months. Lifetime rate of dysthymic disorder was 5.2% (n=90) and 0.9% (n=15) had dysthymic symptoms within the past 12 months. Age was associated with depression and dysthymia. Young participants (18 to 49 years) were less likely to have experienced dysthymia and major depression than the oldest group (50 to 65 years). No association was found by gender on these variables. Negative life events had the strongest and was most consistently associated lifetime prevalence of major depression and dysthymia.

Limitations of this study include the diagnostic measure used. The Composite International Diagnostic Interview assesses retrospective accounts and relies on memory and experiences in the past, thus, subjecting the study to recall bias. This may be problematic for older individuals and for experiences occurring in the distant past. In addition, the researchers used trained nonclinicians in the interviewing of the participants.
The accuracy of the nonclinicians in gathering and interpreting data is unknown. It was not necessary for the participants to speak English. This study provides data for Chinese Americans residing in Los Angeles County but cannot be generalized to Filipino American women who speak English. Despite the limitations, this study is a recent study on Asians and included a large sample size and a heterogeneous sample of individuals who spoke English, Cantonese or Mandarin.

Chung et al. (2003) used the CES-D to measure depressive symptoms among 91 low income Asian and 133 low income Latinos. The researchers also had primary care physicians (PCPs) assess for psychiatric distress among this sample. Results showed that almost half (47.3%, n=63) of the Latino group and 41.6% (n=38) of the Asian group received high scores on the CES-D (≥16), indicating depression. PCPs identified 43.8% (n=58) of Latino patients as being psychiatrically distressed but only 23.6% (n=21) of Asians. The study revealed a similar prevalence of depressive symptoms between Latino and Asian patients (47.3%, n=63 and 41.6%, n=38, respectively) and described the prevalence of depressive symptoms of a low income Asian group and compared them to the Latino group. It provided data on the discrepancy of self reported depressive symptoms and the PCPs identification of depressive symptoms. Findings suggested that there is under identification of depressive symptoms among PCPs when faced with minority patients, especially Asians. However, the Asian group studied was not adequately described, so it is not possible to generalize specifically to Filipino American women.
Ying and Hu (1994) described the use of public outpatient mental health treatment facilities and treatment use and outcomes among Chinese, Japanese, Filipino, Korean, and Southeast-Asian Americans in the Los Angeles area. Data were collected and analyzed from the Los Angeles County Department of Mental Health files from 1983 through 1988. The sample consisted of 1,731 cases including Chinese, Japanese, Filipino, Korean, and Southeastern-Asians, with Filipinos equaling 326 (approximately 19%) of the sample. Results indicate that 27.9% (n=91) of the Filipino sample met the criteria for an affective disorder. In addition, Southeast Asians were more likely to present with anxiety than Chinese, Japanese, and Filipinos. Filipinos were also underrepresented in the Los Angeles mental health system as compared to the census report during that time period. The authors speculated that Filipinos may be underrepresented in the public mental health system as they are usually English proficient and have a greater likelihood of being employed and having private health insurance, and are less likely to utilize public or state owned institutions.

Although this study provides data on the utilization of mental health services for Filipinos in the Los Angeles area, it failed to capture use of services by Filipinos in the private sector, therefore, these results cannot be generalized to Filipinos of higher economic status or to Filipinos in other regions of the country that do not offer county mental health services. It does, however, provide some insight about the willingness of Filipinos to obtain state funded mental health services. This study also provided comparative analysis of documented psychiatric illnesses and treatment utilization among several Asian subgroups.
Hu, Snowden, Jerrell and Nguyen (1991) further described ethnic group differences in mental health service utilizations in two California counties. A total of 26,708 patients who had utilized public mental health services were compared. The sample was comprised of Asians (17%, n=3,825), African Americans (14.5%, n=3,895), Hispanic (14%, n=3842), and Caucasians (56.7%, n=15,146). Eighteen percent (n=688) of the Asian patients were diagnosed with an affective disorder, slightly higher than the African American (15%, n=584) and Hispanic groups (15%, n=576), and lower than the Caucasian group (20%, n=3,029). During 1987 to 1988, 2% (n=70) of Asians utilized inpatient services while 4% (n=531) of Caucasians utilized the same services. Twenty two percent (n=858) of Asians utilized emergency services, while 38% (n=5,727) of Caucasians utilized the same services. However, 66% (n=2,540) of Asians utilized individual outpatient services versus 45% (n=6,876) of Caucasians (Hu et al., 1991). These results show the underutilization of mental health services among Asians, especially emergency and inpatient services, but reveal a high utilization of outpatient services in this group, suggesting perhaps a preference or acceptance of certain mental health services. Although this study is beneficial in describing utilization of psychiatric services, the sample consisted of patients enrolled in the public health care system and is limited to individuals in lower economic status. In addition, this study did not differentiate between men and women.

*Attitudes Toward Depression*

Okazaki (2000) determined length of treatment delay (time from psychiatric symptom onset to appropriate treatment) and stigma of mental illness in a sample of 71
Asian American patients who met the following criteria: 1) Asian descent, 2) over age 18 years, 3) diagnosed with a DSM-IIIR or DSM-IV schizophrenic, schizoaffective, mood or other psychotic disorder, 4) psychiatric disorder not due to organic causes, 5) not currently diagnosed with active post traumatic stress disorder. The participants were recruited from outpatient mental health clinics in the Los Angeles area. These clinics were staffed by bilingual, bicultural Asian clinicians and served mostly Asian clients. A one hour to one and a half hour, face to face, semistructured interview was conducted with each participant by a bilingual interviewer. A written tool, the Stigma Module of the Family Experiences Interview Schedule was used to determine level of stigma of mental illness. Patients’ relatives were also interviewed using the stigma tool. Higher scores indicated greater stigma.

Results indicated that for this sample, patients reported levels of stigma that were significantly higher than the relatives. The mean stigma scale scores were 11.7 for the patients and 6.68 for the relatives. The mean treatment delay for the sample was 17.34 months which is shorter than reported in past studies.

Results clearly demonstrated a negative attitude toward mental illness in this studied group. In addition, the sample included Asian Americans from various subgroups including Chinese, Chinese-Vietnamese, Filipino, Japanese, Korean, and Vietnamese. Filipinos comprised only 8.1% (n=5) of the sample and gender make up of each group was not reported.

Although the sample size included 71 patients, all the participants were recruited from primarily Asian outpatient mental health clinics that were staffed by bilingual Asian
clinicians. More than one half of the sample had reported annual incomes less than $19,999. The findings may not be applicable to Asian Americans of a higher economic status or Asian Americans not receiving treatment in outpatient, culturally sensitive treatment facilities.

Edman and Johnson (1999) assessed the differences in beliefs regarding causes and treatment for depression and schizophrenia between Filipino American and Caucasian college students in Hawaii. The sample consisted of 64 Filipino Americans and 38 Caucasians. The participants were presented with two vignettes. One vignette described an individual experiencing depressive symptoms while the second vignette described an individual experiencing schizophrenic symptoms. The participants were asked to evaluate 23 different causes of the problem and 21 different possible means of treating the problem using Likert scales.

For the depression vignette, the Filipino Americans rated the following causes of depression higher than the Caucasian group: bad luck and weak soul. On the other hand, the Caucasians rated physical causes such as virus and diet higher than the Filipino Americans. In the schizophrenia vignette, the Filipino Americans rated bad luck, too self-centered and guilty conscience higher than the Caucasians. In the same vignette, the Caucasians rated diet and heredity higher than the Filipino Americans.

For the depression vignette, the Filipino Americans rated the treatments of prayer, positive thinking, spending time with family, use of a spiritual healer and relaxing higher than the Caucasians. For the schizophrenia vignette, the Filipino Americans also rated treatments including prayer, positive thinking, spending time with family, sleeping,
appeasing spirits, meditation, use of a spiritual healer and relaxing higher than the Caucasian participants. In general, the Filipino Americans rated more treatments as effective than the Caucasians in both mental disorders. The Filipino Americans appeared to view spiritual and supernatural causes (bad luck and weak soul) and personal and social attributes (too self-centered and guilty conscience) as more important causes of the mental disorder than the Caucasians. On the other hand, Caucasians viewed physical causes such as viruses, germs, diet and heredity as more important causes of the mental disorders than the Filipino Americans. The Filipino Americans rated spiritual treatments such as prayer, appeasing spirits, use of spiritual healers, and mediation, for schizophrenia, while treatments which focused on positive thinking, spending time with family, and relaxation more important in treating depression.

While this study provides data on beliefs of Filipino Americans on depression and schizophrenia, its sample consisted of college students who were in the beginning semester of an introductory psychology course. These participants cannot represent the beliefs of all Filipino Americans. In addition, this study was conducted in Hawaii where the culture may differ from mainland United States. Therefore, the results may not be applicable to a sample gathered from the mainland United States. The participants also were college students and educated. Not all Filipino Americans are college educated. The authors failed to provide demographic information on the participants so the ages, socioeconomic background and years lived in Hawaii were all unknown; thus, making it difficult to determine if the results would be applicable to a sample of similar demographic qualities.
Furnham and Malik (1994) compared the beliefs about the causes and treatment of depression between British Natives and British Asians. The sample included 152 women. The middle aged group included 66 women were between the ages of 35 and 62 years (33=British natives and 33=British Asians), and the younger group included 86 women were between the ages of 17 and 28 years (43=British natives and 43=British Asians). The participants completed the Beliefs about Depression and Anti-Depressive Behavior questionnaire (BDAB) (Rippere, 1977) to determine beliefs about depression. This questionnaire consisted of 20 paired statements that included statements and generalizations pertaining to depression. The participants also completed the Langner Symptom Scale to estimate the individuals’ symptoms of mental illness.

The results indicate that middle-aged British Asians were more likely to think the following statements from the BDAB questionnaire were true than the British participants: It is usually helpful to tell a depressed woman to “pull herself together,” “feeling depressed” is no different from “feeling depressed about something,” Having a job outside the home helps keep women from getting depressed, People get depressed when they lose control over important things that happen to them, It makes no sense for people to get depressed just when they have achieved a goal that has long been important to them, When feeling depressed, it is more helpful to talk it over with a family member than with a friend. On the other hand, the British women thought the opposite statements were true: It is usually no use to tell a depressed woman to “pull herself together,” “Feeling depressed” is not the same as “feeling depressed about something,” Women with jobs outside the home are just as likely to get depressed as women who don’t go out
to work, People get depressed when they realize their plans aren’t going to work out as they had planned, It is understandable for people to get depressed just when they have achieved a goal that has long been important to them, When feeling depressed, it is more helpful to talk it over with a friend rather than with a family member. In addition, the middle-aged Asian women differed significantly with their views on depression from the other groups. They also showed a greater tendency to having psychiatric symptoms compared to the other groups using the Langner Symptom Scale. The young Asian women scored similarly to their British counterparts in their beliefs about depression.

This study provides empiric evidence that culture plays a role in perception of depression. It also provides comparative data on women from various age groups. This study, however, included British Asian women from the subcontinent of India (Bangladesh, India, and Pakistan). Although the sample consisted of women, the British Asian culture differs from the Filipino American culture and may not be applicable to Filipino American women.

Summary

This chapter included a discussion of the theoretical framework for the study. The research presented revealed that depressive symptoms exist in samples of Filipinos and that cultural variation exists in their beliefs about depression. Although some of the research included Filipino women living in other countries, Asian women of different descents, and Filipinos in general, the research provides data that can be pertinent to this understudied subgroup. Recent data pertaining specifically to Filipino American women and depression does not exist.
CHAPTER THREE

Methods

Chapter Three details the design and research questions that were answered by this study. Design, sample, instruments, and methods of data analysis are discussed.

Design

A cross-sectional, descriptive survey was used to describe the prevalence of depression and attitudes toward depression and treatment in a sample of Filipino American women to answer the following questions:

1. What is the prevalence of depression in a sample of Filipino American women?
2. What are the attitudes of Filipino American women toward depression and treatment?
3. Is there a relationship between CES-D score and attitudes of Filipino American women?

Sample

A convenience sample of 35 Filipino American women was recruited in Arizona. Participants were recruited from family contacts, Philippine Nurses Association-Arizona Chapter and by snowball sampling. Early participants were asked if they knew of other Filipino women who might qualify for the study. The sample included self-identified Filipino American women ages between the ages of 23 and 55 years. Descriptive statistics do not require power analyses. However, my intent was to recruit at least 30 subjects, as this number was deemed likely to provide sufficient variability.
To facilitate the use of the English questionnaires, the participants were able to read, write and speak English. No monetary compensation was provided to the participants. Approval for the study was obtained from the University of Arizona IRB/Human Subjects Committee prior to recruitment of participants.

Data Collection Procedures and Data Management

Data were collected by the principal investigator (PI) who is a student in the Psychiatric-Mental Health Nurse Practitioner option of the Master’s program at the University of Arizona College of Nursing. The PI attended Philippine Nurses Association (PNA) board meetings, PNA educational activities and Filipino club social activities. An announcement describing the study and welcoming members to participate was made at the beginning of these activities. The PI was present during and after the activities. Relatives and close family members of the PI were approached individually. A description of the study was verbally communicated and the individual was asked if she was interested in participating. Risks to the participants were explained and signed consent forms were obtained prior to administration of the questionnaires. Participants completed the questionnaires while the PI was present in the same room and participants handed the completed questionnaires to the PI.

This study was supervised by the PI’s research and academic advisor, Dr. Judith Berg. All questionnaires were stored in a locked file cabinet accessible only to the researcher and her advisor. All questionnaires and disks will be destroyed 5 years after publication of the data by shredding. Numbers were assigned to each questionnaire and no identifying information was included in the questionnaire.
Instruments

Three instruments were used to answer the research questions. These include the Women’s Health Questionnaire (WHQ) (Woods, Lentz, Mitchell, Taylor, and Lee, 1986), CES-D (Radloff, 1977), and BDAB questionnaire (BDAB) (Rippere, 1977).

WHQ

The first 14 questions from the WHQ were used to obtain demographic information such as education, employment, residential status, religious preference, political party preference, annual income, and health insurance. In addition, the participants’ age was asked. The WHQ takes approximately 5 minutes to complete. Previous studies have used the WHQ on a large sample of Caucasian midlife women and small samples of Mexican American and African American women (Taylor, 1988, 1994). It has been previously utilized with Filipino American midlife women (Berg, 1999).

CES-D

The CES-D is a self-administered 20 item instrument that measures the level of depressive symptomatology in the general population. The CES-D is designed to measure depressive symptoms. A previous study has shown a high reliability (r=0.89) in a sample of adolescent Filipino Americans (Edman et al., 1999). Scores greater or equal to 16 are in the depressed range. The CES-D takes approximately 5 minutes to complete. The CES-D has been shown to have high internal consistency (Cronbach’s coefficient = 0.83) in a sample of midlife Filipino American women (Berg, 1999). In this present study, Cronbach’s coefficient was 0.95.

BDAB
This self-administered questionnaire (Rippere, 1977) was used to determine the participants’ beliefs about depression. The questionnaire consists of 21 paired statements that include topics on descriptions of antidepressive behavior, judgments about efficacy of treatment for depression, and generalizations on depression. The participant is required to choose one item from each 21 paired statements that reflects their beliefs about depression. This tool has been used in a cross-cultural study on the beliefs of depression (Furnham and Malik, 1994). Reliability and validity data do not exist. This questionnaire takes approximately 10 minutes.

Methods of Analysis

Data were coded and entered into the program Statistical Package for the Social Sciences (SPSS). Descriptive statistics was used to analyze the demographic variables. Age was used as a continuous variable and will be compared with total CES-D score. Pearson’s Product Moment Correlation was used to analyze the relationship between total CES-D score and responses from the BDAB questionnaire. Questionnaires missing more than one-third of responses were eliminated from the study.

Summary

The results of this proposed study will provide data on the prevalence of depression among a sample of Filipino American women. It will focus attention Filipina’s attitudes toward depression. It will allow mental health providers to learn and be educated on the Filipino American woman’s experience with depression. Furthermore, specific interventions and therapies may be utilized to provide culture specific treatment.
Data from this project will also present needed information on the beliefs about depression among Filipino American women. Insight into the beliefs Filipino American women have about depression will allow mental health providers to understand methods to treat and work with these patients. Specifically, it will assist the practitioner in choosing the treatment that will be most acceptable and efficacious to the patient.
CHAPTER FOUR

Result of Analysis of Data

Chapter Four reports the analysis of data. Descriptive statistics were used to summarize the demographics of the sample and to analyze responses on the questionnaires. Pearson’s Product Moment Correlation was calculated to determine the relationship between total CES-D score and attitudes toward depression and treatment.

Sample Characteristics

The sample consisted of 35 self-identified Filipino American women. The participants were recruited from family contacts, Philippine Nurses Association-Arizona Chapter, Filipino club functions, and by snowball sampling. These women fulfilled the following requirements: 1) identified self as Filipino American, 2) ages between 18 and 59 years, 3) ability to read and write English. Table 1 contains the demographic characteristics of the sample.

The mean age of the women was 39.2 ± 9.5 years. The age range was 23 to 55 years. The median age was 37 years. Most of the women were married or living with a partner (62.9%, n=22). Less than half of the participants had children living at home (45.7%, n=16). Approximately one-third (28.7%, n=10) had other family members, such as siblings, aunt, parents, grandparents, and in-laws, also living in the home.

The majority of the women were highly educated. Over half had a college education (62.9%, n=22) and over one-third (31.4%, n=11) had graduate degrees. Most of the women (80%, n=27) were employed as registered nurses, either as staff nurses, nurse
managers, nursing educators or professors. Over half (51.4%, n=18) of the women report total annual household incomes exceeding $50,000. Almost all of the women have some type of health insurance (97.1%, n=34). Over half of the women (68.6%, n=24) reported supervising others in their current job.

The sample was predominately Catholic (80%, n=28) with most reporting that they were at least somewhat religious (88.6%, n=31). Approximately one half (51.4%, n=18) attend weekly church services. Almost half (40%, n=14) of the women report having no political preference and an equal number of women (22.9%, n=8) report being either Republican or Democrat.

**Research Questions**

Research Question One was analyzed using descriptive statistics. Research Question Two was answered by using descriptive statistics. Research Question Three was analyzed using Pearson’s Product Moment Correlation statistics. The results will be presented for each question.

**Research Question One**

Research Question One determines this sample’s prevalence of depression. The CES-D was used as a measurement of depression symptomatology. The CES-D has been shown to have high internal consistency (0.83) in a sample of midlife Filipino American women (Berg, 1999). A score greater or equal to 16 is in the depressed range. Over one third of the sample scored in the depressed range (34.6%, n=12). The mean CES-D score was 14 ± 12.1.
Table 1

**Demographic Characteristics**

<table>
<thead>
<tr>
<th></th>
<th>% (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>23-37 years</td>
<td>51.4% (18)</td>
</tr>
<tr>
<td>38-55 years</td>
<td>48.6% (17)</td>
</tr>
<tr>
<td><strong>Highest grade completed</strong></td>
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</tr>
<tr>
<td>Partial college or specialized training</td>
<td>5.7% (2)</td>
</tr>
<tr>
<td>College graduate</td>
<td>62.9% (22)</td>
</tr>
<tr>
<td>Graduate degree</td>
<td>31.4% (11)</td>
</tr>
<tr>
<td><strong>Supervise others</strong></td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>68.6% (24)</td>
</tr>
<tr>
<td>No</td>
<td>31.4% (11)</td>
</tr>
<tr>
<td><strong>Live Alone</strong></td>
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</tr>
<tr>
<td>Yes</td>
<td>25.7% (9)</td>
</tr>
<tr>
<td>No</td>
<td>74.3% (26)</td>
</tr>
<tr>
<td><strong>Live with Spouse</strong></td>
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</tr>
<tr>
<td>Yes</td>
<td>65.7% (26)</td>
</tr>
<tr>
<td>No</td>
<td>34.3% (23)</td>
</tr>
<tr>
<td><strong>Current Relationship</strong></td>
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</tr>
<tr>
<td>Single or living alone</td>
<td>34.3% (12)</td>
</tr>
<tr>
<td>Married or living with a partner</td>
<td>62.9% (22)</td>
</tr>
</tbody>
</table>
### In past year, how often attended church

<table>
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<tr>
<th>Frequency</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Not at all</td>
<td>2.9% (1)</td>
</tr>
<tr>
<td>More than once a week</td>
<td>11.4% (4)</td>
</tr>
<tr>
<td>Once a week</td>
<td>51.4% (18)</td>
</tr>
<tr>
<td>2 to 3 times a month</td>
<td>20.0% (7)</td>
</tr>
<tr>
<td>A few times a year</td>
<td>11.4% (4)</td>
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### Religious Preference

<table>
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<tr>
<th>Preference</th>
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</tr>
</thead>
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<tr>
<td>Catholic</td>
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</tr>
<tr>
<td>Buddhist</td>
<td>2.9% (1)</td>
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<tr>
<td>Nondenominational Christian</td>
<td>5.7% (2)</td>
</tr>
<tr>
<td>Islam</td>
<td>2.9% (1)</td>
</tr>
<tr>
<td>Born Again Christian</td>
<td>2.9% (1)</td>
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### Political Party Preference

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<thead>
<tr>
<th>Preference</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
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<tr>
<td>Republican</td>
<td>22.9% (8)</td>
</tr>
<tr>
<td>Democrat</td>
<td>22.9% (8)</td>
</tr>
<tr>
<td>Independent</td>
<td>11.5% (3)</td>
</tr>
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</table>

### Total annual household income

<table>
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<tr>
<th>Income Range</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>$7,501-$15,000</td>
<td>2.9% (8)</td>
</tr>
<tr>
<td>$15,001-$25,000</td>
<td>2.9% (8)</td>
</tr>
<tr>
<td>$25,001-$35,000</td>
<td>11.4% (4)</td>
</tr>
<tr>
<td>Income Range</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------</td>
<td>------------</td>
</tr>
<tr>
<td>$35,001-$50,000</td>
<td>25.7%</td>
</tr>
<tr>
<td>&gt;50,000</td>
<td>51.4%</td>
</tr>
</tbody>
</table>

Health Care Coverage

<table>
<thead>
<tr>
<th>Coverage</th>
<th>Percentage</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>97.1%</td>
<td>(34)</td>
</tr>
<tr>
<td>No</td>
<td>2.9%</td>
<td>(1)</td>
</tr>
</tbody>
</table>
Individual CES-D items pertaining specifically to depressive symptomatology will be reported. Most women (62.9%, n=22) reported having little problem with appetite (Statement 2, “You did not feel like eating, your appetite was poor”).

Over half (51.4%, n=18) of the women reported feeling that they could not feel better with the help of family or friends (Statement 3, “You felt that you could not shake off the blues even with help from your family or friends”). Over one third (31.4%, n=11) reported feeling this way some or a little of the time. Almost twenty percent (17.1%, n=6) reported feeling occasionally or a moderate amount of time, and 2.9% (n=1) reported feeling this way most or all of the time.

Over half (60%, n=21) of the women reported feeling depressed to some degree (statement 6, “You felt depressed”). Forty percent (n=14) reported feeling depressed some or a little of the time, 11.4% (n=4) reported feeling depressed occasionally or a moderate amount of the time, and 8.6% (n=3) reported feeling depressed most of all of the time.

Only half (51.4%, n=18) of the women reported feeling happy most or all of the time (Statement 12, “You were happy”). Twenty eight percent (28.6%, n=10) of the women felt happy occasionally or a moderate amount of time. Seventeen percent (17.1%, n=6) reported feeling happy some or a little of the time, while 2.9% (n=1) felt feeling happy rarely or none of the time.

Over half (54.3%, n=19) of the women reported feeling sad to some degree (Statement 18, “You felt sad”). Over one third (37.1%, n=13) reported feeling sad some
or a little of the time, 8.6% (n=3) reported feeling sad occasionally or a moderate amount of time, and 8.6% (n=3) reported feeling sad most or all of the time.

A majority (57.1%, n=20) of the women felt lonely (Statement 14, “You felt lonely”). Over one third (37.1%, n=13) felt lonely some or a little of the time, 11.4% (n=4) felt lonely occasionally or a moderate amount of the time, and 8.6% (n=3) felt lonely most of the time.

Most (51.5%, n=18) of the women reported have restless sleep at least once in the last week (Statement 11, “Your sleep was restless”). Over one quarter (28.6%, n=10) reported having restless sleep at least some or a little of the time, 14.3% (n=5) reported restless sleep occasionally or a moderate amount of the time, and 8.6% (n=3) reported having restless sleep most or all of the time.

Most women (77%, n=27) report rarely or never having crying spells (Statement 17, “You had crying spells”), while 14.3% (n=5) report having crying spells some or a little of the time, 5.7% (n=2) report having crying spells occasionally or a moderate amount of the time, and 2.9% (n=1) reported having crying spells most or all of the time in the past week.

Most women (62.9%, n=22) felt hopeful about the future most or all of the time (Statement 8, “You felt hopeful about the future). Most participants (65.7%, n=23) reported enjoying life most of all of the time (Statement 16, “You enjoyed life”). Seventeen percent (17.1%, n=6) reported enjoying life occasionally or a moderate amount of time, 11.4% (n=4) reported some or a little of the time, and 2.9% (n=1)
reported rarely or never enjoying life in the past week. A complete analysis of the chosen responses grouped into age groups is reported in Table 2.

*Additional exploratory data.*

Pearson’s Correlation statistic did not reveal a significant correlation between age and total CES-D score ($r = 0.001$, $p = 0.996$). The t-test was also used to compare the mean CES-D score between 2 age groups (<37 years and 37 years and older). The age of 37 was selected as the cut-off point as it was the median age of the sample. Results indicate no significant difference in total CES-D score between these 2 age groups. T-test revealed the mean CES-D score to be $14.7 \pm 12.9$ in the <37 age group and $13.3 \pm 11.6$ in the 37 years and older group ($t = 0.358$, df = 33, $p = 0.723$).

*Research Question Two*

Research Question Two examines the women’s attitudes toward depression and treatment. Certain questions from the BDAB questionnaire were used to answer this question focused on views on treatment for depression. The questionnaire consists of paired statements and the participant is required to choose one item from each paired statement that reflects their belief about depression. A complete analysis of the chosen responses grouped into age groups is reported in Table 2.

Most women (68.6%, $n = 24$) believed the following statement (2a) to be true: When people feel depressed, they most often try and do something about it. Approximately one third (31.4%, $n = 11$) believed the paired statement (2b) to be true: When people feel depressed, they most often just give in and do nothing.
Almost all (91.4%, n=32) of the women felt the following statement (3a) to be true: The things people do to help themselves when they are depressed are often more helpful than the things other people do to help them, while only 8.6% (n=3) believed the opposite statement (3b) to be true: The things people do to help themselves when they are depressed are often less helpful than the things other people do to help them.

A majority (85.7%, n=30) of the women found the following statement (4a) to be true: When feeling depressed, it is most helpful to do something one enjoys. The
Table 2

Beliefs about Depression and Anti-depressive Behavior Questionnaire Responses

<table>
<thead>
<tr>
<th>Paired Statements</th>
<th>Total Sample % (n)</th>
<th>&lt;37 years % (n)</th>
<th>≥37 years % (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1a</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>1b</td>
<td>100% (35)</td>
<td>100% (16)</td>
<td>100% (19)</td>
</tr>
<tr>
<td>2a</td>
<td>68.8% (24)</td>
<td>41.6% (10)</td>
<td>58.3% (14)</td>
</tr>
<tr>
<td>2b</td>
<td>31.4% (11)</td>
<td>54.5% (6)</td>
<td>45.4% (5)</td>
</tr>
<tr>
<td>3a</td>
<td>91.4% (32)</td>
<td>46.8% (15)</td>
<td>53.1% (17)</td>
</tr>
<tr>
<td>3b</td>
<td>8.6% (3)</td>
<td>33.3% (1)</td>
<td>66.6% (2)</td>
</tr>
<tr>
<td>4a</td>
<td>85.7% (30)</td>
<td>43.3% (13)</td>
<td>56.6% (17)</td>
</tr>
<tr>
<td>4b</td>
<td>14.3% (5)</td>
<td>60% (3)</td>
<td>40% (2)</td>
</tr>
<tr>
<td>5a</td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>5b</td>
<td>100% (35)</td>
<td>45.7% (16)</td>
<td>54.2% (19)</td>
</tr>
<tr>
<td>6a</td>
<td>28.6% (10)</td>
<td>50.0% (5)</td>
<td>50.0% (5)</td>
</tr>
<tr>
<td>6b</td>
<td>71.4% (25)</td>
<td>44.0% (11)</td>
<td>56.0% (14)</td>
</tr>
<tr>
<td>7a</td>
<td>62.9% (22)</td>
<td>54.5% (12)</td>
<td>45.4% (10)</td>
</tr>
<tr>
<td>7b</td>
<td>34.3% (12)</td>
<td>23.0% (3)</td>
<td>75.0% (9)</td>
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<td>8a</td>
<td>62.9% (22)</td>
<td>40.9% (9)</td>
<td>59.0% (13)</td>
</tr>
<tr>
<td>8b</td>
<td>37.1% (13)</td>
<td>53.8% (7)</td>
<td>46.1% (6)</td>
</tr>
<tr>
<td>9a</td>
<td>71.4% (25)</td>
<td>52.0% (13)</td>
<td>48.0% (12)</td>
</tr>
<tr>
<td>9b</td>
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<td>33.3% (3)</td>
<td>66.7% (6)</td>
</tr>
<tr>
<td>10a</td>
<td>82.9% (29)</td>
<td>48.3% (14)</td>
<td>51.7% (15)</td>
</tr>
<tr>
<td></td>
<td>10b</td>
<td>11a</td>
<td>11b</td>
</tr>
<tr>
<td>---</td>
<td>-------</td>
<td>-------</td>
<td>-------</td>
</tr>
<tr>
<td></td>
<td>17.1% (6)</td>
<td>33.3% (2)</td>
<td>66.7% (4)</td>
</tr>
<tr>
<td></td>
<td>14.3% (5)</td>
<td>80.0% (4)</td>
<td>20.0% (1)</td>
</tr>
<tr>
<td></td>
<td>85.7% (30)</td>
<td>40.0% (12)</td>
<td>60.0% (18)</td>
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<tr>
<td></td>
<td>82.9% (29)</td>
<td>51.7% (15)</td>
<td>48.3% (14)</td>
</tr>
<tr>
<td></td>
<td>17.1% (6)</td>
<td>16.7% (1)</td>
<td>83.3% (5)</td>
</tr>
<tr>
<td></td>
<td>17.1% (6)</td>
<td>16.7% (1)</td>
<td>83.3% (5)</td>
</tr>
<tr>
<td></td>
<td>82.9% (29)</td>
<td>51.7% (15)</td>
<td>48.2% (14)</td>
</tr>
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<td>68.6% (24)</td>
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<td>31.4% (11)</td>
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<td>54.5% (6)</td>
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<tr>
<td></td>
<td>62.9% (22)</td>
<td>50.0% (11)</td>
<td>50.0% (11)</td>
</tr>
<tr>
<td></td>
<td>37.1% (13)</td>
<td>38.5% (5)</td>
<td>61.5% (8)</td>
</tr>
<tr>
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<td>40.0% (14)</td>
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<td>45.7% (16)</td>
<td>43.8% (7)</td>
<td>56.2% (9)</td>
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<tr>
<td></td>
<td>100.0% (35)</td>
<td>100% (16)</td>
<td>100% (19)</td>
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<tr>
<td></td>
<td>0 (0)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td></td>
<td>54.3% (19)</td>
<td>42.1% (8)</td>
<td>57.9% (11)</td>
</tr>
<tr>
<td></td>
<td>45.7% (16)</td>
<td>50.0% (8)</td>
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<td>60.0% (21)</td>
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<td>39.1% (9)</td>
<td>60.9% (14)</td>
</tr>
<tr>
<td>21b</td>
<td>34.3% (12)</td>
<td>58.3% (7)</td>
<td>41.7% (5)</td>
</tr>
</tbody>
</table>
remaining (14.3%, n=5) women believed the opposite statement (4b) to be true: When feeling depressed it is most helpful to do something that needs doing.

All the participants believed the following statement (5a) to be true: If someone is feeling depressed, there is probably something she can do about it. Almost three quarters of the sample (71.4%, n=25) believed the following statement (6b) to be true: It is usually helpful to tell a depressed woman to “pull herself together.” The remaining women (28.6%, n=10) of women believed the other statement (6a) to be true: It is usually no use to tell a depressed woman to “pull herself together.”

More than half (64.7%, n=23) of the women believed the following statement (7a) to be true: When someone is feeling depressed she should try and deal with it herself rather than consulting a psychiatrist. Only 35.3% (n=12) believed the opposite statement (7b) to be true: When someone is feeling depressed she should consult a psychiatrist rather than dealing with it herself.

Most (82.9%, n=29) of the women believed that it is helpful to keep busy when feeling depressed (10a). Only 17.1% (n=6) believed the following statement (10b) to be true: When feeling depressed it usually helps to take it easy. Similarly, most women (85.7%, n=30) believed the following statement (11b) to be true: Keeping busy when feeling depressed is a way of coping with your problems. Only 14.3% (n=5) believed the paired statement (11a) to be true: Keeping busy when feeling depressed is a way of running away from your problems.

Most women (82.9%, n=29) believed the following statement (12a) to be true: When feeling depressed, it is often more helpful to talk it over with a friend rather than a
doctor. Only 17.1% (n=6) believed the paired statement (12b) to be true: When feeling depressed, it is often more helpful to talk it over with a doctor rather than a friend.

Slightly greater than half (54.3%, n=19) of the women believed the following statement (17a) to be true: Having someone to tell her troubles to isn’t likely to prevent a woman from getting depressed. The remainder (45.7%, n=16) of the women, believed the opposite statement (17b) to be true: If a woman has someone to tell her troubles to, she is less likely to get depressed.

Over half of the women (65.7%, n=23) believed the following statement (21a) to be true: When feeling depressed, it is more helpful to talk it over with a family member rather than a friend. On the other hand, 34.3% (n=12) reported the paired statement (21b) to be true: When feeling depressed, it is more helpful to talk it over with a friend rather than a family member. All women believed the following statement (18a) to be true: When a depressed woman recovers, she should take most of the credit herself.

Research Question Three

Research Question Three examined the relationship between total CES-D score and attitudes toward depression as measured by the BDAB questionnaire. Pearson’s Correlation statistics was used to examine each statement of the questionnaire to the total CES-D score. Analysis of the variables showed a significant relationship between total CES-D score and three of twenty-one questionnaire statements.

Pearson’s Correlation statistics revealed a significant positive relationship between total CES-D score and statement 2 (r=0.422, p=0.01). The higher the CES-D score, the more likely that statement 2b is chosen, “When people feel depressed, they
most often just give in and do nothing” rather than statement 2a, “When people feel depressed, they most often try and do something about it.”

There was also a significant positive relationship between total CES-D score and statement 8 (r=0.366, p=0.031). The higher the CES-D score, the more likely that statement 8b was chosen, “A depressed woman is often better able to cope with her job than with her home and family,” rather than statement 8a, “A depressed woman is often no better at coping with her job than with her home and family.”

There was a strong positive correlation between total CES-D score and statement 16 (r=0.527, p=0.001). The higher the CES-D score, the more likely the participant chose statement 16b, “People get depressed when they realize their plans aren’t going to work out as they had planned,” rather than statement 16a, “People get depressed when they lose control over important things that happen to them.”

Summary

This chapter presented the results of the analysis of the research questions. The results indicate that over one third (34.6%, n=12) of the sample scored in the depressed range, using the CES-D. The mean CES-D score was 13.94 ± 12.09. There was no significance of the mean total CES-D score when the 2 age groups were compared. Women under the age of 37 had a mean CES-D score of 14.75 ± 12.9, while the women 37 years and older had a means CES-D score of 13.26 ± 11.6. Most of the women believed statements reflecting self help when experiencing depression to be true. A majority of the women also believed that it is more helpful to talk about depression with a
friend or family member, rather than a doctor. Pearson’s Correlation statistics revealed a positive correlation between total CES-D score and Statements 2, 8, and 16.
CHAPTER FIVE

Discussion

The purpose of this cross-sectional, descriptive survey was to describe the prevalence of depression and attitudes toward depression and treatment in a sample of 35 Filipino American women. Descriptive statistics were used to analyze the demographic characteristics, prevalence of depression, and attitudes toward depression and treatment. Pearson’s Product Moment Correlation was also used to further analyze the relationship between total CES-D score and attitudes of Filipino American women.

Research Question One

This study determined that 34.6% of the sample scored in the depressed range of the CES-D. This rate is higher than previous studies using the same questionnaire. Berg (1999) reported that 24.8% (n=41) of a sample of midlife Filipino American women scored in the depressed range and suggested that this high rate may be due to instrumentation problems with immigrants whose second language is English. In the current study, years lived in the United States and acculturation was not measured; therefore, it is possible that instrumentation problems may have affected the data. English may be a second language for many of the study participants.

The prevalence of depression in this study was significantly lower than Miller and Chandler’s (2002) results which determined that 84% (n=168) of 200 midlife women from the former Soviet Union scored in the depressed range when the CES-D was used. The difference between the two groups may be due to recent immigrant experiences of the women from the former Soviet Union and unique demographic characteristics. The
women from the Soviet Union had immigrated to the United States after the age of 40 and had lived in the United States less than 6 years. As mentioned earlier, date of immigration was not determined with this sample of Filipino American women.

Chung et al. (2003) report a higher (41.6%, n=38) prevalence of depression among low income Asians using the CES-D. The higher rate of depression may be associated with belonging to a lower economic bracket and less years of education (8 years) compared to the Filipino American women sample, where more than half of the participants had annual household incomes greater than $50,000 and were college educated. Chung et al.’s study also did not differentiate between Asian groups and may contribute to the higher rate of depression as other Asian subgroups were included. The prevalence of depression found in this study is slightly higher than the prevalence of mental distress found in Filipinas living in Queensland, Australia (Thompson et al., 2002). Thompson and colleagues determined that in a sample of 487 Filipinas, 23% had mental distress higher than the Australian general population. Although Thompson uses the General Health Questionnaire (GHQ-28) rather than the CES-D, these prevalence rates are both higher than the 12% prevalence rate of depression among American women. This current study’s prevalence rate may be higher than the Filipinas living in Australia as the Australian women were surveyed at baseline and one year later. The cross sectional approach with the current study provides only a one week analysis of depressive symptomatology. This higher rate of depression may also be a factor of the acculturation process.
These results do not concur with Takeuchi et al.’s (1998) Chinese American study. The lifetime rate for major depression among a sample of 1,747 male and female Chinese Americans was 6.9% (n=120) and 3.4% for a major depressive episode in the past 12 months. There was no association between sex and depressive episodes. The difference in results may be due to methodology. Takeuchi et al. used the DSM-III-R criteria rather than a screening questionnaire to determine the prevalence of depression. In addition, the demographic characteristics varied between the two groups. Only 59% (n=1,030) of the Chinese American sample had some college education and 19% (n=331) had annual incomes greater than $50,000, which suggests that in the Chinese American sample, wealth and education did not significantly impact depressive episodes.

Research Question Two

Most participants chose statements that reflected views of taking an active approach when faced with depression. Most of the women (68.6%, n=24) believed the following statement to be true (2a): When people feel depressed, they most often try and do something about it. In addition, a majority (91.4%, n=32) of the women believed the following statement (3a) to be true: The things people do to help themselves when they are depressed are often more helpful than the things other people do to help them. These two statements suggest that self-help may be preferred over either not acting or having others help with treatment. It may reflect an ownership of the depression and self-empowerment to take care of the depression. Similarly, all of the women chose the statement (18a): When a depressed woman recovers, she should take most of the credit herself. This implies that actions a woman takes in recovery are more important than
what others have done to help. Most (64.7%, n=23) women chose the statement favoring dealing with depression by herself rather than a doctor (7a). This may be due to feeling embarrassed or shameful when asking help from the medical community as most of the participants are nurses. It may suggest that the participants believe that depression can be treated solely by the actions of the individual.

Most women chose statements that reflected a preference to talk with family or friends about depression than with a doctor. Most (82.9%, n=29) women believed it to be more helpful to talk with a friend than a doctor. Most of the women (65%, n=23) believed it was more helpful to talk with a family member than a friend (21a). The women may feel more comfortable talking about depression to other members of the cultural group or family members rather than a physician, who may not be aware of their needs or culture.

*Research Question Three*

Data analysis revealed a significant positive relationship between total CES-D score and statement 2. In other words, the higher the CES-D score, the more likely that statement 2b is chosen, “When people feel depressed, they most often just give in and do nothing,” rather than statement 2a, “When people feel depressed, they most often try and do something about it.” Statement 2b reflects feelings of hopelessness and giving up, which is a symptom of depression.

There was also a significant positive relationship between total CES-D score and statement 8. The higher the CES-D score, the more likely that statement 8b was chosen, “A depressed woman is often better able to cope with her job than with her home and
family,” rather than statement 8a, “A depressed woman is often no better at coping with her job than with her home and family.” This can be interpreted as the more depressed a woman becomes, the less able she is to cope with her home and family and is better able to cope with her job. Perhaps the more depressed a woman becomes, the more she focuses on work issues. It is possible that as a Filipino woman becomes more depressed, she works harder at hiding her depressive symptoms from co-workers but allows herself to be depressed around her family.

There was a strong positive correlation between total CES-D score and statement 16. The higher the CES-D score, the more likely statement 16b was chosen, “People get depressed when they realize their plans aren’t going to work out as they had planned,” rather than the paired statement, “People get depressed when they lose control over important things that happen to them.” Statement 16b reflects a loss of control over ones plans and life. The more depressed one becomes, the more they feel that depression is caused by one’s plans that have not been fulfilled (internal locus of control). On the other hand, the lower the CES-D score, the more likely that paired statement is chosen, which reflects a loss of control over things that happen to them (external locus of control).

**Implications for Nursing Practice**

Although Filipinos are the fastest growing Asian subgroup, there is little research devoted to Filipino American women. This study contributed to the limited data available on Filipino American women and depression. This study profiles a small sample of Filipino American women.
The conclusion that over one third (34.6%, n=12) of the sample scored in the depressed range has implications for nursing practice. This rate of depression is higher than the national average for American women in the same age group. Nurses must screen Filipino American women for depression when they are seen at primary care appointments or in other health care facilities. In addition, they must be able to provide culturally competent care.

The results of Research Question Two that most participants chose statements reflecting taking action to treat depression and taking most of the credit for recovery, reveals that these Filipino American women do want to treat their depression and that treatment may be actions that the woman does for herself rather than outside sources of help. This suggests that nurses may offer alternative remedies for depression that involve an active role for the woman, like joining a special interest club or choosing a new hobby. Involvement in such activities does not carry stigma associated with mental illness and increases a woman’s interactions with others and focuses attention on pleasurable activities.

The result that most women would rather talk with family members or friends rather than a doctor is significant to nursing. This implies that these Filipino American women are less likely to talk with a physician or medical providers about their feelings. As mentioned earlier, the nurse must screen Filipino women for depression and offer nonjudgmental, culturally competent care. Friends and family members of depressed Filipino women must also be encouraged to assist the depressed women in seeking
medical assistance for depression. Education regarding depression and the benefits of psychopharmacological interventions may also benefit this population.

The strong positive correlation between total CES-D score and statement 16 also has implications for nursing practice. This statement reflects that the greater level of depression, the more likely the woman believe that depression is caused by one’s plans that have not been fulfilled rather than losing control of what happens to her. It implies that the woman feels that she had some control over the cause of her depression. As mentioned earlier, education on depression and causes of depression would benefit this population.

The results of the study support the use of the CES-D by a Psychiatric Mental Health Nurse Practitioner or other health care providers in a busy primary care health setting to screen patients for depression. The CES-D takes only 5 minutes to complete and quickly provides the health care provider with a total CES-D score. A total CES-D score greater than 16 can trigger questions aimed at screening for depressive symptomatology and generate communication between provider and patient. The total CES-D score may also be used by a Family Nurse Practitioner or physician to assist in determining appropriate referrals to a Psychiatric Mental Health Nurse Practitioner or psychiatrist for further psychiatric treatment and follow up.

Limitations of the Study

A limitation of this study is the sample size. Only 35 participants were included and all participants were localized to the state of Arizona. Women living in southwestern United States may have values and beliefs differing from women residing in other parts
of the country. In addition, only women between the ages of 18 and 59 years were included. Data from women from other age groups may yield different results. Despite this limitation, this sample was community based, and included only active women with no acute illnesses.

In addition, the CES-D is a depression screening tool and is not used to diagnose clinical depression; therefore, a CES-D score greater than or equal to 16 alone cannot suggest clinical depression. Furthermore, the high rate of depression in this sample may be due to instrumentation problems with the CES-D.

The homogeneity of the sample is another limitation. The majority of the women were nurses. Nurses may possess beliefs and values that are different than other occupations. In addition, most of the women had total annual incomes greater than $50,000 (51.4%) and most were college graduates (62.9%). This limited variability may influence views on depression. Furthermore, a majority of the women considered themselves religious (88.6%). Religiosity may affect ones views on depression and treatment. Participants were recruited from the Philippine Nurses Association and Filipino club social events. Individuals active in organizations may have common ideals and values that attract them to be involved in certain organizations.

Despite the limitations, this study provides baseline data for this understudied group. This study illustrates the views toward depression and treatment among this group of Filipino women. This was one of the limited studies focusing on Filipino American women and depression.
Recommendations for Future Research

To provide a comprehensive picture of this group, a larger sample size is necessary. Only 35 women participated in this study and a larger sample size would yield data more representative of the population. A more diverse group of Filipino women would also yield a more representative sample. Future studies should include women from lower incomes and occupations, and women from other regions of the United States.

Further studies should also determine level of acculturation and years lived in the United States among the sample. This data may provide a clearer explanation of varying views on depression and treatment and the prevalence of depression.

Future studies on Filipino women should also determine specific views and attitudes on Western medical interventions versus non-Western interventions. Furthermore, barriers to seeking medical attention should also be examined. This information would assist medical professionals in screening for depression among Filipino women and would also aid in culturally competent care.

A study comparing CES-D results and a concurrent psychiatric diagnostic interview may be helpful in determining the usefulness of the CES-D. Such a study will determine the accuracy of the CES-D in predicting a psychiatric diagnosis and will provide the medical provider with data on benefits of utilizing the CES-D in the clinical setting.
Chapter 5 presented the conclusions to Research Questions 1, 2 and 3, implications for nursing research, implications for nursing practice, limitations and strengths of the study, and recommendations for future research. Implications for nursing practice include appropriate depression screening, culturally competent care, and providing education regarding depression and its causes. Limitations of the study include sample size and limited variability among participants. Strengths of the study include the collection of baseline data for this understudied group. This study illustrates the views toward depression and treatment among this group of Filipino women. Recommendations for future research include the use of a larger and more inclusive sample and examining specific views and attitudes on Western medical interventions and barriers to seeking psychiatric treatment.
APPENDIX A: WOMEN’S HEALTH QUESTIONNAIRE (WHQ)
1. What was the highest grade or year of school you completed?
   1. Less than 7th grade
   2. Junior high school
   3. Partial high school (10th or 11th grade)
   4. High school graduate
   5. Partial college or specialized training
   6. College graduate
   7. Graduate degree
   8. Unsure or decline to state

2. What is your current employment status?
   1. Working full-time
   2. Working part-time
   3. Temporarily laid off
   4. Unemployed
   5. Homemaker
   6. Student
   7. Volunteer
   8. Retired

3. If you have been or are employed, please describe your current or most recent job.
   (Write in your answer)
   Occupational/Job Title               Type of Business or Industry
   1. _______________________  ________________________
   2. _______________________  ________________________

4. In your current or most recent job, did you supervise the work of others or tell
   other employees what work to do?
   0. No
   1. Yes
   2. 

5. Who lives at home with you now? (Check all that apply)
   1. Live Alone
   2. Spouse/Partner
   3. Children
   4. Step Children
   5. Parents
   6. Roommate(s)
   7. Sister
   8. Mother
   9. Other (specify)_______________________________
6. Which of the following best describes your current relationship?
   1 Single or living alone
   2 Married or living with a partner
   3 Divorced or separated
   4 Widowed

7. If applicable, please indicate your spouse’s/partner’s main occupation.

<table>
<thead>
<tr>
<th>Occupation/Job Title</th>
<th>Type of Business or Industry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1._______________________</td>
<td>_________________________</td>
</tr>
<tr>
<td>2._______________________</td>
<td>_________________________</td>
</tr>
</tbody>
</table>

8. People have different religious practices. Some attend services regularly, and others do not attend services. In the past year, about how often have you attended religious services?
   0 Not at all
   1 More than once a week
   2 Once a week
   3 Two or three times a month
   4 Once a month
   5 A few times a year

9. Do you consider yourself very religious, somewhat religious, or not at all religious?
   0 Not at all religious
   1 Somewhat religious
   2 Very religious

10. What is your religious preference at the present time?
    0 No religious preference
    1 Protestant (denomination)_________________________
    2 Catholic
    3 Jewish
    4 Other (specify)_________________________

11. What is your political party preference at this time?
    0 No preference
    1 Republican
    2 Democrat
    3 Independent
    4 Other (specify)_________________________
12. Politically, would you say that you are a:
   1  Radical
   2  Liberal
   3  Middle-of-the-roader
   4  Conservative
   5  Strong conservative
   6  Don’t know

Income levels profoundly affect women’s access to health care. For this reason, we are asking about you and your family’s income. Remember, all information is confidential.

13. Check the appropriate range to indicate your total household income for the past year before taxes, no matter what the source. This figure should include income from your partner and/or parent if appropriate as well as your own.
   1  $7,500.00 or less
   2  $7,501.00-$15,000.00
   3  $15,001.00-$25,000.00
   4  $25,001.00-$35,000.00
   5  $35,000.00-$50,000.00
   6  $50,001.00 or more
   7  Unsure or decline to state

14. Check the item(s) which best describe your health insurance coverage. (Check all that apply)
   0  No coverage
   1  Blue Cross/Blue Shield
   2  Other private insurer (specify name if known)
   3  Military
   4  Veteran’s Administration
   5  Health Maintenance Organization (HMO)
   6  Preferred Provider Organization (PPO/IPO)
   7  Medicare
   8  Medicaid/MediCal
   9  Other (specify)_______________________
APPENDIX B: BELIEFS ABOUT DEPRESSION AND ANTI-DEPRESSIVE BEHAVIOR
Beliefs about Depression and Anti-Depressive Behavior  
(Rippere, 1977)

Below are 21 pairs of statements about depression. In each pair circle the letters (a or b) that you think is nearer the truth. (I would like to stress that there are no correct or incorrect answers).

1 (a) Most people never feel depressed  
     (b) Most people feel depressed at some point or the other

2 (a) When people feel depressed, they most often try and do something about it  
     (b) When people feel depressed, they most often just give in and do nothing

3 (a) The things people do to help themselves when they are depressed are often more helpful than the things other people do to help them  
     (b) The things people do to help themselves when they are depressed are often less helpful than the things other people do to help them.

4 (a) When feeling depressed, it is most helpful to do something one enjoys  
     (b) When feeling depressed it is most helpful to do something that needs doing

5 (a) If someone is feeling depressed, there is probably not much she can do about it  
     (b) If someone is feeling depressed, there is probably something she can do about it

6 (a) It is usually no use to tell a depressed woman to “pull herself together”  
     (b) It is usually helpful to tell a depressed woman to “pull herself together”

7 (a) When someone is feeling depressed she should try and deal with it herself rather than consulting a psychiatrist  
     (b) When someone is feeling depressed she should consult a psychiatrist rather than dealing with it herself.

8 (a) A depressed woman is often no better at coping with her job than with her home and family.  
     (b) A depressed woman is often better able to cope with her job than with her home and family.

9 (a) “Feeling depressed” is not the same as “feeling depressed about something”  
     (b) “Feeling depressed” is no different from “feeling depressed about something”

10 (a) When feeling depressed it usually helps to keep busy  
       (b) When feeling depressed it usually helps to take it easy
11 (a) Keeping busy when feeling depressed is a way of running away from your problems
(b) Keeping busy when feeling depressed is a way of coping with your problems

12 (a) When feeling depressed, it is often more helpful to talk it over with a friend rather than a doctor
(b) When feeling depressed, it is often more helpful to talk it over with a doctor rather than a friend

13 (a) Feeling “unhappy” is just the same as feeling depressed
(b) Feeling “unhappy” is not the same as feeling depressed

14 (a) Women with jobs outside the home are just as likely to get depressed as women who don’t go out to work
(b) Having a job outside the home helps keep women from getting depressed

15 (a) People get depressed when they haven’t got enough to do
(b) People get depressed when they have got more to do than they can manage

16 (a) People get depressed when they lose control over important things that happen to them
(b) People get depressed when they realize their plans aren’t going to work out as they had planned

17 (a) Having someone to tell her troubles to isn’t likely to prevent a woman from getting depressed
(b) If a woman has someone to tell her troubles to, she is less likely to get depressed

18 (a) When a depressed woman recovers, she should take most of the credit herself
(b) When a depressed woman recovers, her doctor should take most of the credit

19 (a) It rarely helps to tell a depressed woman to go and buy herself new clothes
(b) It often helps to tell a depressed woman to go and buy herself new clothes

20 (a) It makes no sense for people to get depressed just when they have achieved a goal that has long been important to them
(b) It is understandable for people to get depressed just when they have achieved a goal that has long been important to them

21 (a) When feeling depressed, it is more helpful to talk it over with a family member rather than a friend
(b) When feeling depressed, it is more helpful to talk it over with a friend rather than a family member
APPENDIX C: CENTER FOR EPIDEMIOLOGICAL STUDIES

DEPRESSION SCALE (CES-D)
Center for Epidemiological Studies Depression Scale (CES-D)

**Instructions:** I am going to read a list of ways you may have felt. Please tell me how often you have felt this way during the past week: rarely or none of the time; some or a little of the time; occasionally or a moderate amount of time; or most or all of the time.

During the past week, that would be from _____ through today:

<table>
<thead>
<tr>
<th></th>
<th>Rarely or none of the time (less than 1 day)</th>
<th>Some or a little of the time (1-2 days)</th>
<th>Occasionally or a Moderate Amount of Time (3-4 days)</th>
<th>Most or all of the time (5-7 days)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. You were bothered by things that usually don’t bother you.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. You did not feel like eating; your appetite was poor.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. You felt that you could not shake off the blues even with help from your family or friends.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. You felt that you were just as good as other people.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>5. You had trouble keeping your mind on what you were doing.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. You felt depressed.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. You felt that everything you did was an effort.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. You felt hopeful about the future.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>9. You thought your life had been a failure.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10. You felt fearful.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>11. Your sleep was restless.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>12. You were happy.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>13. You talked less than usual.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>14. You felt lonely.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>15. People were unfriendly.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>16. You enjoyed life.</td>
<td>3</td>
<td>2</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>17. You had crying spells.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>18. You felt sad.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>19. You felt that people disliked you.</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>20. You could not get “going.”</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**To total:** Add all circled numbers in each column
References


