Culturally Informed Psychosocial Stress Assessment For Hispanics

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There is a striking lack of culturally informed mental health assessments, procedures, and tools to facilitate detection and accurate diagnosis for Hispanics seeking mental health care (Malgady & Zayas, 2001; Cervantes & Acosta, 1992; Cervantes, Fisher, Cordova, & Kilp, 2011). Many psychological assessment tools for Hispanics today are still limited to translations of existing clinical and research measures that are not normed on appropriate Hispanic populations (Cervantes & Acosta, 1992; Yamada, Valle, Barrio, & Jeste, 2006). Instead, according to Rodriguez (1997) assessments of how Hispanics perform on psychological tests are generally developed, validated and standardized on a non-minority, White, middle-class population. The lack of reliable and valid tests normed on samples of Hispanics populations, both Spanish-speaking and English-speaking, is a significant obstacle in the overall assessment of Hispanics (Bird et al., 1987; Loewenstein et al., 1994; Velasquez et al., 1998). Psychological testing can also be affected by many factors, especially such as language and cultural factors. Several studies found that language ability, level of acculturation as well as socioeconomic issues must be taken into consideration when providing assessments to Hispanic populations (Schwartz, Unger, Zamboanga & Szapoeznik, 2011). To date, few measures have been developed and disseminated specifically tailored to the contexts of the Hispanic population. In addition, research has made it evident that Hispanics, in response to stressful events, may manifest symptoms that are culturally bound, Culture Bound Syndromes, such as susto (fright), mal de ojo (evil eye) and nervios (nerves) or ataque de nervios (Guarnacia, Canino, Rubio-Stipec, & Bravo, 1993; Guarnacia, Lewis-Fernandez, & Rivera-Marano, 2003). This chapter will provide a current state knowledge on what is known about Hispanic mental health assessments and present new assessments that are focused on culturally informed stressor evaluations for children and adults, as well as implications for treatment planning and cultural tailoring of clinical interventions.
Constituting the largest minority group in the U.S., Hispanics have grown by 56% in numbers over the past ten years, and the population is expected to constitute one fourth of the U.S. population (an estimated 97 million) by the year 2050. Approximately 40% of Hispanics are foreign born and migrate to the U.S. for a variety of reasons, ranging from economic and social advancement to political freedom (Suarez-Orozco & Suarez-Orozco, 2001). In comparison to non-Hispanic Whites, Hispanic adults in the U.S. experience disproportionate rates of morbidity and mortality in five major physical health conditions: stroke, chronic liver disease, diabetes, HIV, and asthma (Relations, 2006; Smedley, Stinth, & Nelson, 2002). In one important on-going national survey conducted by the CDC, Hispanic youth consistently demonstrated higher rates of depressive thinking, feelings of hopelessness, suicidal ideation and suicide attempts requiring medical treatment, most categories of substance abuse and violent behavior than non-Hispanic White and African-Americans (Centers for Disease Control and Prevention (CDC) & Prevention, 2006a). Moreover, many of these mental health disparities have persisted over time. In the 1997 national survey, Hispanic youth endorsed more suicidal ideation and behaviors (U.S. Department of Health and Human Services, 1999). Further, the negative impact of being a minority group member, minority related stress, acculturation and exposure to prolonged and chronic discrimination has been shown to result in poor mental health among minority youth (Brody, Chen & Murray, 2006). Stress-related disorders (e.g. post traumatic stress disorders) also seem to impact Hispanics to a higher degree than other groups in American society (Galea et al., 2002; Perilla, Norris, & Lavizzo, 2002; Pole, Best, Metzler, & Marmar, 2005). Other behavioral health disparities exist with Hispanic youth demonstrating higher rates than whites and African-Americans for current alcohol use, alcohol use to intoxication, current

Access to the U.S. health care system, include mental health services is limited for both U.S. born and immigrant Hispanics (Ruiz, 2002), emphasizing the importance of early screening and detection of emotional problems among adolescents. For example, fewer than 10% of U.S. born Latinos who have mental disorders contact mental health specialist and the lack of health insurance is a significant barrier to general health and mental health care for many Hispanics.

Key Assessment Issues for Hispanic Adults

Quality mental health care requires the use of valid diagnostic and clinical assessment tools and procedures (Cervantes & Acosta, 1992). There have been numerous advances in the development of mental health assessment and diagnostic tests and inventories for adults in general (Hunsley & Mash, 2005). Most of this development and research has aimed at specifying psychological symptomatology and distinct emotional disorders. Various studies have also assessed Spanish translated tools for Hispanics in the areas of psychological testing for mental disorders (Butcher, Dahlstrom, Graham, Tellegen, & Kaemmer, 1989), personality assessment (Morey, 1991), projective tests (Cueller, 1998; Grossman, Wasyliw, Benn & Gyorkoe, 2002; Pedroso-Roche, Nazaro, & Suarez-Kindy, 2012). Further, the role of acculturation in diagnosing and understanding mental health from an emic, Hispanic perspective has gained considerable attention over the past two decades (Schwartz, Unger, Zamboanga and Szapoeznik, 2011, yet this construct is measured inconsistently at best.

Related specifically to culture and stress, work has also been done in the area of the development of culturally appropriate measures for assessing stress among Hispanic adults
(Barona & Miller, 1994). Cervantes, Padilla, and Salgado de Snyder (1991) developed both immigrant and nonimmigrant versions of the Hispanic Stress Inventory (HSI) to assess stress events across six life domains, including acculturation stress. There is now also an abbreviated version of the HSI (Cavazos-Rehg, Zayas, Walker, & Fisher, 2006). Other stress and diagnostic assessment tools specific to Hispanics that are culturally-based measurement instruments do exist. For example, the Acculturation Rating Scale for Mexican Americans-II (ARSMA-II; Cuellar, Arnold, & Maldonado, 1995) was developed as a multidimensional assessment to measure levels of acculturation in Mexican-Americans and is widely used. Rodriguez and colleagues (2002) created the Multidimensional Acculturative Stress Inventory (MASI; Rodriguez, Myers, Mira, Flores, & Garcia-Hernandez, 2002). Recently, Butcher and colleagues (2007) also revised the Minnesota Multiphasic Personality Inventory (MMPI-2) for use with Hispanic clients.

**Key Assessment Issues for Hispanic Adolescents.**

There have also been numerous advances in the development of mental health assessment and diagnostic tests and inventories for children and adolescents in the general population (Kotsopoulos, Walker, Copping, Cote, & Stavrakaki 1994). Like with adults, most of this development and research focuses on psychological symptomatology and distinct emotional disorders. A major gap remains, however, in measures specific to ethnic minority group adolescents in the United States, including Hispanic youths. This void is particularly relevant because Hispanic youths are at greater risk of exposure to community based challenges and acculturation stressors relative to their European American counterparts (Cordova & Cervantes, 2010).
The development of assessment tools specifically for Hispanic youth populations has largely been limited to translation and cultural adaptation of existing tools and measures and has not assessed acculturation related stress exposure (e.g., Eisen et al., 2010). The New Freedom Commission’s Final Report (The President’s New Freedom Commission on Mental Health, 2003) affirmed the need to eliminate disparities in behavioral health services and expand and improve early mental health screening, assessment, and referral in Hispanic populations.

Several tools have been developed for Hispanic youth populations, although most have been designed specifically to address unique research hypotheses in cross sectional studies of Hispanic populations. Originally developed for adult Hispanics, the Social, Attitudinal, Familial and Environmental Scale (SAFE) (Mena, Padilla, & Maldonado, 1987; A. Padilla, 1988) and the Hispanic Stress Inventory (HSI) (Alva & de Los Reyes, 1999; Chavez, Moran, Reed, & Lopez, 1997; J. Hovey, 1998; J. Hovey & King, 1996) have been used for children and adolescents. The Bicultural Stressors Scale (BSS), which focuses on age appropriate domains of perceived stress in a bicultural Mexican-American context has been developed (Romero & Roberts, 2003). One gap, however, in assessment science is the lack of measures of psychological status specific to ethnic minority group adolescents in the United States, more specifically, Hispanic youths. In spite of the fact that Hispanics now constitute the largest ethnic minority group in the United States (U.S. Census Bureau, 2007), there is a dearth of mental health and stress assessment instruments that are culturally tailored to meet the needs of this highly overlooked and understudied population (Cervantes, Cordova, Fisher, & Kilp, 2008). This deficiency is particularly relevant because Hispanic youths are at risk of exposure to increased community based challenges and acculturation-related stressors, relative to their European American counterparts (Cordova & Cervantes, 2010).
Assessing Stress Events within the Acculturation Context

The acculturation process itself may best be framed within a stressful life-events paradigm (Rudmin, 2009). This theory that postulates that social organization plays a significant role in the origins and consequences of stressful life experiences (Aneshensel, 1992). Further, Lazarus and Folkman (1984) articulated the concept of stress appraisal, which is the subjective (negative) psychological reaction to a specific stress event or set of events. Similarly, negatively appraised stressor events related to acculturation within the Hispanic population are an important antecedent for mental health problems in both adults and children (Cervantes et al., 1991; Rogler, Cortes, & Malgady, 1991; Vega & Gil, 1998). Berry (1991) described “acculturation stress” as the result of one’s culture of origin interacting with host culture values, attitudes, customs, and behaviors. Individuals and families from one cultural orientation who are constantly being exposed to new, novel, and challenging events and situations require some form of psychological and behavioral adjustments. Exposure to racial or ethnic discrimination (negative behaviors toward Latino youths) can constitute a source of daily stress (Romero & Roberts, 2003).

As a group, many Hispanics face particularly chronic stressful circumstances. For example, Hispanics experience stress related to socioeconomic status (U.S. Census Bureau, 2010), discrimination, and family separation due to immigration (Taylor & Seeman, 1999). Stressful life events are connected to a multitude of negative health and behavioral health outcomes (IOM, 2009; NIDA, 1995), and as a group, many Hispanics are facing particularly stressful circumstances. Hispanics face disparate health outcomes including difficulty controlling high blood pressure, heightened rates of asthma, and increased risk for diabetes and cardiovascular disease (MMWR, 2011). Hispanics also face heightened rates of HIV (CDC,
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2007), substance use and alcoholism (NSDUH, 2007) and mental health concerns (Prado, et al., 2007). Further, Hispanics have high rates of unemployment, which is related to a myriad of negative outcomes including poorer health outcomes and a lack of health insurance (U.S. Census, 2010).

Research on stressful events in adolescents has also resulted in a proliferation of measures (Mullis & Youngs, 1993) and has substantiated adolescent stress as an important factor in the development of psychological and physiological risk factors (Compas, Davis, Forsythe, & Wagner, 1987). Existing measures of child and adolescent stress fall into four categories (Grant, 2001): (1) response-oriented measures that assess the effects of the stress experience (e.g., Children's Depression Inventory; Kovacs, 2006; Kovacs & Beck, 1977; Sitarenios & Kovacs, 1999); (2) interactional measures which largely deal with how individuals cope with stressors (e.g., Stress Response Scale; Curtis & Adams, 1991); (3) stimulus-event measures which assess the types of stressors endured, as well as some perceived aspect of the experience (e.g., Adolescent Perceived Events Scale; Compas et al., 1987; Life Events and Difficulties Schedule; Duggal et al., 2000); and (4) a combination of the above (e.g., Responses to Stress Questionnaire; Connor-Smith et al., 2000; Stress Inventory for Children; Macil, 1996).

Perhaps the most promising of the newer measures of adolescent stress is the Responses to Stress Questionnaire (RSQ; Connor-Smith et al., 2000). Overall, the RSQ demonstrated excellent reliability and validity with its original samples (Connor-Smith et al., 2000), as well as with a sample of 332 Navajo adolescents (Wadsworth, Rieckmann, Benson, & Compas, 2004). Many of these tests are translated and used in clinical settings with Hispanic children and adolescents despite the lack of culturally specific norms (Cervantes & Acosta, 1992).
Cervantes, Goldbach, & Berger-Cardoso (under review) compared clinical and non-clinical Hispanic adolescent youth, including a sample of youth presenting with diagnosed behavioral health issues. Comparing levels of culturally based stress between clinical and non-clinical youth, they showed that in fact cultural stress is much more profound among those youth who present with clinical disorders. Nearly all aspects of HSIA related stress factors were found to be significantly higher in that clinical sample. Culturally based stressors, including chronic stress related to discrimination, personal and family experienced immigration issues, school-based peer and social stress, among others, were all found to be significantly higher in the clinical sample. The study also demonstrated a significant link between cultural stress and CDI depression, suggesting that more prospective, longitudinal studies are needed to demonstrate the cultural stress etiology of depression, particularly among Latina adolescents.

Cervantes et al. (under review) also examined the role of generational status on was related to different categories of stressor experience. Using survey data from the Hispanic Stress Inventory-Adolescent Version (HSI-A; Cervantes et al., 2011), they examined psychosocial stress across eight domains including family economic stress and acculturation-gap stress in a national sample of three generations of Hispanic adolescents (N=1,263). Research questions addressed generation differences in frequency of stressor events (i.e., discrimination), appraisal of these events, and resulting behavioral health outcomes. Similar levels of discrimination stress were reported by participants regardless of generation, but depression and behavioral health outcomes differed across the groups. An acculturation paradox was found with greater stress exposure and higher stress appraisals in first generation youth, but with lower negative behavioral health outcomes than later generations. Family integrity and more traditional family
values may buffer the negative impact of greater stressor exposure among immigrant and 2nd generation youth when compared to 3rd generation adolescents.

Psychological research on stress responses, including coping, has grown well beyond early definitions of the adult stress-coping research of Lazarus and Folkman (1984). Specifically, the role of coping and adjustment to stressful life events in adolescence is a growing area of mental health research (Compas & Boyer, 2001; Moos, 2004). Further, stress-coping processes in adolescence are associated with multiple factors related to the interaction of both normative developmental change and non-normative chronic stressors (Colten & Gore, 1991). Ineffective coping among adolescents has been linked to behavioral problems such as substance use, depression, and suicide (Garcia, 2010; Rew, 2005). While very limited, research suggests that there may also be unique coping strategies that Hispanic youth actively employ, including ethnic identity affirmation (Edwards & Romero, 2008). Little, however, is known about other coping strategies for cultural stress (Greene, et al., 2006; Rodriguez & Morrobel, 2004). There is an additional concern about the lack of available, culturally sensitive and appropriate mental health assessment instruments for Hispanics (Compas, et al., 2001; Malgady & Zayas, 2001). Hispanic adolescents face particularly stressful circumstances, including anti-immigrant attitudes, family separation issues (McGuire & Martin, 2007), high rates of poverty, lack of school achievement and constant negative public references toward their ethnic identity (Cervantes et al., 2011; Cervantes & Cordova, 2010). These culturally based stressors have been linked to mental health problems (Rogler, 1994; U.S. DHHS, 2001; Vega et al., 1993; 1998). For example, a recent study by Cervantes et al (2011) found that Hispanic adolescents experience culturally based stressors in eight discrete domains, and that these are significantly related to both internalized
(i.e., anxiety) and externalized (i.e., conduct disorder) behavioral health problems as well as depression as measure by the CDI-2 (Kovacs, 2006). Other studies have also found that young Hispanics in the U.S. adapt to the values of a new culture more quickly than their parents (Phinney et al., 2000), which may increase tension in the family and contribute to psychological maladjustment and suicide attempts (Zayas et al., 2005).

Development of the Hispanic Stress Inventories for Adults and Adolescents

The Hispanic Stress Inventory (HSI) and the Hispanic Stress Inventory – Adolescent Version (HSIA) were developed to bring the research and practice related to assessment of acculturation stress and mental health. These tools were created to serve as a culturally sensitive screening and assessment tools for clinicians and researchers that detect stress related risk among Hispanic adults and adolescents respectively. Clinicians, educators and other health care professionals can use these tools to ensure a seamless continuity of care in transitioning special populations of Hispanic who may otherwise go unnoticed or untreated.

The Hispanic Stress Inventory (HSI) was developed to aid researchers and clinicians in the assessment of the culturally based stress processes of both U.S.-born and foreign-born Hispanic adults (Cervantes, Padilla, & Salgado de Snyder, 1990). The HSI included two versions, one for immigrants (five subscales) and one for non-immigrants (four subscales). The Immigrant version of the HSI includes an “Immigration Stress” subscale (e.g. I thought I would be deported if I went to a social or governmental agency”), and both versions include Marital Stress (e.g. “There have been cultural conflicts in my marriage”) Occupation/Economic Stress (e.g. “I have been forced to accept low paying jobs”), Parental Stress (e.g. “I thought that my children were not receiving a good education”) and Family/Cultural Conflict Stress (e.g. Being too close to my family interfered with my own goals”). All subscales were empirically

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derived using factor analysis and proved to have strong relationship to other standardized measures of mental health (see Table 1). In a second series of NIH funded studies to re-standardize the original HSI with a national sample of Hispanic adults, finding new stressor themes and valid item content for a new version of the instrument (Hispanic Stress Inventory – Version 2) was completed (Cervantes, Goldbach & Padilla, 2012). The largest number of new HSI2 stress items was generated for the Access to Healthcare Stress (37 items), followed by Immigration Stress Domain (33 items), Parent Stress (32 items), Cultural Conflict Stress (26 items), Occupational and Economic Stress (21 items), Marital Stress (20 items), and Family Stress (18 items) (Cervantes, Goldbach & Padilla, 2012).

**Hispanic Stress Inventory-Adolescent Version.** Hispanic adolescents experience significant health disparities and are exposed to intense contextual challenges (Cordova & Cervantes, 2010; Santisteban & Mena, 2009). The NIMH-funded research projects on Hispanic adolescent stress led to the development of the Hispanic Stress Inventory-Adolescent version (HSI-A; Cervantes et al., 2011). These studies found important differences in the specificity and context of adolescent stressors (Cordova & Cervantes, 2010), impact of discrimination stress exposure among Hispanic adolescents (Cervantes & Cordova, 2011), and the impact of school-related stress on mental health outcomes (Cervantes & Shelby, 2013). Additionally, these studies have articulated eight distinct cultural contexts of Hispanic adolescent stress, and how these stressors vary and impact the mental health of 1st, 2nd, and later generations of youth (Cervantes et al., under review). Cervantes et al. (2011) systematically developed an instrument that would have high utility to both professionals and researchers who, respectively, practice and conduct research with foreign-born and U.S.-born Hispanic adolescents. Specifically, they aimed to establish the psychometric properties and factor structure of the HSI-A, a culturally informed
stress assessment specifically tailored to Hispanic adolescents (Cervantes et al., 2011). The development of the HSI–A version was grounded on the previous pioneering work of Cervantes et al. (1991) in the area of assessment in Hispanic populations. Exploratory factor analysis procedures were implemented and yielded an interpretable eight-factor solution, with factors labeled Family Economic Stress (e.g. “My family had problems paying rent”), Acculturation-Gap Stress (e.g. “My parents want me to maintain customs and traditions from our home country”), Culture and Educational Stress (“Teachers think I am cheating when I am speaking Spanish”), Immigration-Related Stress (“I had to leave family members behind in my home country”), Community and Gang-Related Stress (“There was a lot of pressure for me to get involved in gangs”), Discrimination Stress (“Students made racist comments”), Family and Drug-Related Stress (“A family member had a drug problem”), and Family Immigration Stress (“Family members were afraid of getting caught by immigration officials”). Further, our study demonstrated that the HSI–A has strong concurrent evidence of validity with measures of psychological symptomatology. The HSI–A total and subscale stress appraisal scores also show well-acceptable estimates of internal consistency. Future research on the final HSI–A final eight subscale version is needed to determine the utility of the tool and to determine whether it is appropriate for use in clinical settings. The HSIA subscales and correlations with concurrent mental health measures are presented in Table 2. Findings from the study by Cervantes et al. (2011) suggest that appraisals of stress as measured by the HSI–A are associated with higher levels of symptoms related to psychopathology and behavioral and conduct problems, as well as higher levels of emotional disturbance among youth participants. Separately, many of the HSI–A subscales show unique relationships with particular behavioral and emotional syndromes. One subscale factor, Acculturation-Gap Stress, appears to be one of the more robust measures of

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psychosocial stress in Hispanic adolescents, with high scores corresponding to increased risk for childhood depression as measured with Kovacs’s (2006) CDI. The HSI–A, when compared with other assessment measures, has the unique ability to screen for culturally based stressor events such as acculturation gaps, family immigration stress, and discrimination stress. The role of acculturation gaps and related problems among youths and the potential for these problems to increase depression in this population is in need of much more study.

The HSI–A has also been used in a number of other studies to develop or measure prevention and intervention related outcomes in Hispanic adolescents, including the drug prevention trial, The Familia Adelante (Cervantes, Goldbach, & Santos, 2011). The HSI–A has also been used to inform other interventions including Culturally Informed and Flexible Family-based Treatment (CIFFTA; Santisteban & Mena, 2009).

**Using HSI and HSIA for Cultural Tailoring of Interventions**

Cultural tailoring as defined by Pasick et al., (1996) and Resnicow et al., (1999) is generally characterized as the process of developing or modifying interventions or materials to ensure their cultural sensitivity—that is, their conformity to pertinent characteristics of the population targeted. The developers of health promotion programs are often advised to engage in cultural tailoring (Boles, Casas, Furlong, Gonzalez, & Morrison, 1994; Kandel, 1995; B. Marin et al., 1995; Pasick et al., 1996; Sanders, 2000) to incorporate into their prevention materials the norms, values, and experiences of the populations targeted (Marin et al., 1995). Support for cultural tailoring is also provided by several theoretical perspectives. Successful culturally-based interventions, Demmert and Towner (2003) believe, comprise several key elements, including the use of persons’ primary language, congruence of strategies with traditional cultural characteristics, and references to community values and mores. The literature suggests important
core values that preventive interventions should consider; for example, “respect for elders,” “familismo,” “fatalism,” and “positive social interactions” or “simpatia” among Hispanics (Kreuter et al., 2003; G. Marin, Marin, Perez-Stable, Sabogal, & Otero-Sabogal, 1990; Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999; Sabogal, Otero-Sabogal, Pasic, Jenkins, & Perez-Stable, 1996; Szapocznik, 1989).

The HSI and HSIA instruments have a potentially large impact for mental health service systems in the U.S., and one of the few culturally appropriate measures of psychosocial stress for the fastest growing population in the U.S. (U.S. Census Bureau, 2010). Both instruments provide knowledge that is directly applicable to the design, delivery, and support of effective mental health coping and risk prevention services for an underrepresented and understudied population of Hispanic adolescents. Clinicians who use the HSI and HSIA measures can more effectively:

- Identify cluster of problematic culturally based stressors, including chronic and acute and stress exposure;
- Use information from HSIA and HSI to develop a culturally tailored individualized treatment plan;
- Provide clients with assessment information about their own cultural life experience that is not commonly provided – help Hispanic clients “normalize” their stress experiences;
- Use HSIA and HSI in the context of family treatment to identify unique parent-child patterns of stress.
• Use HSIA and HSI for re-assessment and monitoring of progress related to cultural stress issues.

Conclusion

The need to reduce the mental health disparities gap in the Hispanic population through the use of accurate early detection and screening assessments has been well documented. Research on the development of Hispanic specific assessment tools has lagged far behind the general research in this area. Moreover, much of the development has been limited to translation (and test adaptation) of current existing objective assessments, inappropriate use of white non-Hispanic norm or reference groups, and lack of establishing validity for use with the Hispanic population. To the best of our knowledge, there currently are no readily available and accessible Hispanic-based assessment tools for use in screening, diagnosis or treatment planning efforts. To not take into account factors embedded within the Hispanic experience that mediate mental health (e.g., acculturation, language use, citizenship status), arguably, runs an end result risk of misdiagnosis, inappropriate treatment, and premature termination (Cervantes & Acosta, 1992; Prieto, McNeil, Walls, & Gomez, 2001). This is remarkable given the sheer size of the Hispanic population and their need for behavioral health services.

In order to begin addressing the gap in psychometrically sound, sensitive, and culturally appropriate coping measurement, future research will need to test the feasibility of producing a culturally relevant coping instrument for Hispanic adolescents. In the absence of such measures, both explanatory research and informed mental health promotion/prevention programs lack the specificity needed to advance these respective discipline areas. Research into the utility of the
HSI and HSI–A’s potential as screening and early detection tools is needed. Culturally informed early screening and assessment with tools such as the HSI–A may prove beneficial to school personnel, as well as to trained clinicians who desire more relevant diagnostic information for treatment planning purposes.
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Table 1

*Pearson Correlations of Hispanic Stress Inventory Sub Scales with Criterion Measures*

<table>
<thead>
<tr>
<th>Subscales</th>
<th>CES-D</th>
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<th>SCLR90</th>
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<td>.38*</td>
<td>.34*</td>
<td>.29*</td>
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Immigration version (N=305)

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<td>Immigration</td>
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<td>.40*</td>
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*p < .05, *p < .01, **p < .001. Note: CES-D=Center for Epidemiological Studies Depression Scale (Radloff, 1977); SCL-90-R=Symptom Checklist (Derogatis, 1977).
Table 2

*Hispanic Stress Inventory- Adolescent Version Sub Scales and Correlations with Concurrent Mental Health Measures -*Children’s Depression Inventory (CDI) and Youth Self Report Total (YSR)*

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<th>YSR Total</th>
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<td>Community and Gang-Related Stress</td>
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"p < .05. ""p < .01. """"p < .001.