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Factor Structure of the *Escala de Autoeficacia para la Depresión en Adolescentes* (EADA)

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Abstract

The current concept and measures of self-efficacy for depression in adolescents do not consider developmental and cultural aspects essential to understand and assess this construct in Latino youth. We examined the factor structure of the *Escala de Autoeficacia para la Depresión en Adolescentes* (EADA): a Spanish instrument designed to assess this construct as experienced by this population. Participants were 116 Puerto Rican adolescents aged 13 to 17 years who completed the EADA and two other self-report measures. An exploratory factor analysis yielded a two-factor solution (Personal Self-Efficacy for Depression and Interpersonal Self-Efficacy for Depression) accounting for 37.57% of the total variance. Results revealed that EADA factors have excellent internal consistency as well as concurrent and construct validity, supporting its adequacy to assess Latino adolescents' self-efficacy for depression. The conceptual meaning of the factors was consistent with the distinction between aspects of this construct hypothesized to be important among Latino youth.

Keywords

self-efficacy for depression; adolescents; Latinos/Hispanics; culturally-sensitive assessment; psychometrics

Many self-report measures have been developed to assess different aspects of self-efficacy. In several studies, adults and adolescents with low self-efficacy have reported higher levels of depression (Comunian, 1989; Ehrenberg Cox, & Koopman, 1991; Muris, 2001). These findings supported the idea of developing a scale that assesses the particular aspects of self-efficacy that can contribute to the etiology/maintenance of depression symptoms in adolescents. Tonge and colleagues validated the Self-efficacy Questionnaire for Depression in Adolescents (SEQ-DA; Tonge et al., 2005) with a sample of 130 depressed Australian youth. Nevertheless, in order to properly assess this construct in Latino youth, a measure that directly responds to their experiences and cultural values is needed (Canino & Guarnaccia, 1997).

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According to Bandura (1997), individuals possess a self-system that enables them to exercise a measure of control over their thoughts, feelings, motivations, and actions. This self-system provides reference mechanisms and a set of sub-functions for perceiving, regulating, and evaluating behavior, which result from the interplay between the system and environmental sources of influence. As such, it serves as a self-regulatory function by providing individuals with the capability of influencing their own cognitive processes, feelings and actions and thus altering their environments. This self-system is known as *self-efficacy*, but the term *perceived self-efficacy* is a more precise label to use in the context of its psychological measurement.

Bandura (1997) postulated that self-efficacy plays a mediator role in the etiology and/or maintenance of depression. This role corresponds to the lack of confidence to execute a desirable action when negative situations influence our thoughts, behavior, and even our feelings about us, others and the future. In addition, Bandura (1997) proposed other cognitive processes that could promote depression in adolescents. The first one corresponds to thoughts that arise when a person cannot accomplish the desired goals. These goals are based not only in one's expectations, but also those from other people, such as parents, teachers or people that have confidence in the person's abilities. The second process is a perceived low social self-efficacy, which disables one's ability to maintain interpersonal relationships. The last process indicates the lack of control over ruminative thoughts. Each process plays an important role in adolescent depression.

Adolescence is a transitional developmental phase in which a person confronts unique and demanding challenges (Erikson, 1968; Feldman, 1999) that impact the development and execution of perceived self-efficacy. This process occurs in the context of at least four typical adolescence's challenging areas: hormonal/physical (puberty and sexual maturation); social (establishing new friendships; confronting peer, family and societal pressure; engaging in romantic relations; combined with worries about establishing own family), academic/cognitive (increased moral, intellectual and achievement demands, combined with worries about career selection), and self-image/emotional (identity crisis, emotional lability/turmoil, and ambivalence between the strive for independence and the actual need for the support of significant others). Each youth must manage adequately these challenges to develop self-confidence. According to Bandura (1997), adolescents develop depression if their self-perception evokes mistrust in their performance to obtain the desirable outcomes in one or more of these areas. It is evident that these challenges are not faced by youth in a vacuum, but in a social and interpersonal context where family, peers, teachers and other significant people could serve both as role models, facilitators and emotional resources, or as obstacles that hinders their efforts in this process.

After reports by Comunian (1989) and Ehrenberg et al. (1991), several self-efficacy measures had been used to study the relation between this construct and youth depression. For example, Bandura, Pastorelli, Barbaranelli, and Caprara (1999) developed a measure to analyze how different aspects of self-efficacy influenced childhood depression. They found that both low social and academic self-efficacy were predictive of long-term depression, while this relation was not so strong with self-regulatory efficacy. Consequently, they argued

that the efficacy for the self-regulation of affect represented another pathway to childhood depression.

This research team also developed a scale to measure perceived self-efficacy to manage both positive and negative affect (Caprara et al., 1999). They defined *emotional self-efficacy* as the capability to monitor, recognize, discriminate, express, value, know and experiment our own and others' emotions and use these as guidance for our own thoughts and actions. The scale targeted three areas of self-efficacy related to: (1) comprehend emotions (capacity to recognize and monitor our own and others' emotions); (2) experience emotions in a adaptive way (ability to control our own negative emotions and to express the positive ones); and (3) utilize the emotions (ability to use the emotions related towards the resolution of a conflict, and the capacity to give and to ask for help with the same purpose). They found that a strong efficacy to manage positive emotions (i.e., to express liking/affection towards others, to experience empathy and joy, and to cheer oneself under discouraging circumstances) predicted high prosocialness, and a low efficacy to manage negative situations predicted more depressive withdrawal only for females.

Two years later, Muris (2001) developed a general self-efficacy scale (SEQ-C; see *Measures*) that included an emotional self-efficacy subscale (ESES), targeting the perceived capability to manage only negative emotions. ESES scores correlated stronger with youth depression compared with social and academic self-efficacy. Furthermore, girls reported lower ESES scores than boys. The SEQ-C included two items addressing youth self-confidence (a) to express their feelings and (b) to ask for teacher's help when stuck on schoolwork. The first item was included in the ESES, and the second in the academic self-efficacy subscale. Noteworthy, by its inclusion, Muris (2001) was the first to acknowledge the importance of expressing feelings and asking for help/support as developmentally appropriate self-efficacy-related issues in youth.

Perraud (2000) validated the first adult self-efficacy for depression (SED) scale (the Depression Coping Self-efficacy Scale) and defined the construct as the confidence one has to "perform tasks designed to provide some control over depressive symptoms" (p. 276). The author included three items related to seeking others' help/support or expressing own feelings to others as means to cope with experiences associated with depression. Such items assess the confidence to: (1) *Tell others how I feel in a socially acceptable manner*; (2) *Ask for help when I am having trouble understanding something because I am not concentrating well*; and (3) *Get together with at least one very close person when I am feeling lonely*.

Influenced by Perraud and other researchers' work (Perraud, 2000; Tucker, Brust, & Richardson, 2002), Tonge et al. (2005) developed the SEQ-DA: the first scale to assess SED in adolescents. The authors defined the construct as the perceived ability to cope with depression symptoms. Although it was a major contribution to the field, many SEQ-DA items (at least 9 out of 12) were related to DSM-IV diagnostic criteria for a major depressive episode. Even though their authors claimed they considered "age-related developmental features of depression" when deciding item selection (Tonge et al., 2005, p. 359), this short measure only included one item to assess self-efficacy behaviors related to interpersonal aspects of depression. In fact, this item only addresses youth self-confidence in talking to

unfamiliar people (*people you didn't know very well*), but excludes significant others. Although Tonge et al. (2005) considered Perraud's work when developing the SEQ-DA, they failed to address properly the interpersonal tasks related to SED in youth, even when they are in more need of such self-efficacy skills than adults. In fact, to include such items in a SED scale seems crucial, since supportive family and peer relations act as a protective shell against youth depression (Bandura et al., 1999). More so for Latino youth, who by their cultural characteristics are described as valuing interdependence over independence, and family and interpersonal needs over individual ones (Bernal, Cumba-Avilés, & Sáez-Santiago, 2006; Hovey & King, 1996).

The importance attributed among Latinos to reach family and friends for support, even as first-hand resources when coping with physical and mental symptoms, seems to be greater than among those with European-American descent, who are deemed to value more independence, self-help strategies, and seeking first-hand help from professionals than Latinos (Kenny & Stryker, 1996; Kessler et al., 1996; Vega et al., 1998). Moreover, Latino families who actually seek psychological treatment for their depressed son/daughter have "an especially strong emphasis on family, which translated into care and concern among family members, as well as a willingness to support and help each other through the treatment experience" (Sweeney, Robins, Ruberu, & Jones, 2005, p. 226). Thus, to properly assess this construct in Latino adolescents, a SED measure has to respond to their experiences and cultural values. It should not only assess youth confidence in having healthy social interactions (i.e., to avoid social isolation) but also their perceived self-efficacy for using social networks as resources to cope with depression.

Depression represents the fourth most frequent pediatric mental disorder in Puerto Rico (Canino et al., 2004). About 4.42% of Puerto Rican youth aged 11 to 17 meet criteria for a Major Depressive Disorder (MDD), and an additional 5.25% meet criteria for Minor Depression, a sub-threshold depressed group associated with similar correlates as MDD (González-Tejera et al., 2005). Since youth depression itself and the diversity of its associated problems (i.e., suicidal behavior; poor school achievement; family conflict; increase mental health care costs; and increase risk for substance use, anxiety, and conduct disorders) are a current scientific and serious public concern, the development of a self-report measure to assess the specific aspects of self-efficacy related to Puerto Rican adolescents' depression seems essential. This is especially true since it has been found that improved self-efficacy results in decreased depression and that higher SED scores predict lower post-treatment and follow-up depressive symptoms and an increased general functioning (Kavanagh & Wilson, 1989; Perraud, Fogg, Kopytko, & Gross, 2006; Tucker et al., 2002; Tucker, Burst, Pierce, Fristedt, & Pankratz, 2004).

We argued that a new measure of SED in youth is necessary to enhance the current definition of the construct, and to accurately assess SED in Latino adolescents. The objective of this study was to examine the factor structure of a measure that assesses SED in Latino youth with a developmentally and culturally appropriate approach: the *Escala de Autoeficacia para la Depresión en Adolescentes* (Self-efficacy for Depression Scale-Youth). We also examined the psychometric properties of the factorial total and subscales scores of the instrument.

Method

Participants

Participants were 116 adolescents (75 females) aged 13 to 17 years ($\bar{X} = 14.54$; $SD = 1.10$) that attended to a public school (grades 8th through 11th) in San Juan, Puerto Rico. The mean size of their family households was of 4.04 members ($SD = 1.02$), with a range from 2 to 7.

Measures

Escala de Autoeficacia para la Depresión en Adolescentes (EADA; Díaz-Santos, Cumba-Avilés, Bernal, & Rivera-Medina, 2008)—It was developed to measure specific self-efficacy beliefs related to coping with activities, cognitions, feelings, daily tasks and situations commonly faced by adolescents “even if feeling sad, angry/irritable, lonely or discouraged”. It consists of 28 items that evaluate perceived coping skills in the last two weeks on a scale ranging from 1 (*Never*) to 5 (*Always*). Higher scores reflect greater perceived SED. EADA’s item pool was developed considering a literature review, items from other scales, developmental aspects, and particular cultural issues hypothesized to influence depression among Latino adolescents. A group of experts assessed items’ content validity and correspondence with developmental and cultural considerations. Efforts were also made to target the four relevant areas of thoughts, activities, interpersonal relationships, and functionality known to be clinically important in adolescents’ depression. The first three are core content elements in the culturally adapted Cognitive Behavioral Therapy (CBT) Manual for Depression (Muñoz, Aguilar-Gaxiola, & Guzmán, 1986; Rosselló & Bernal, 2007). Other areas assessed by its items are mood and other depression symptoms, and coping strategies related to asking for advice or support, or expressing one’s own feelings to others when depressed. A detailed description of the EADA development (including results from a focus group to assess its adequacy to target Puerto Rican youth values and experiences) is available elsewhere (Díaz-Santos et al., 2008).

Self-efficacy Questionnaire for Children, Emotional Self-efficacy subscale (SEQ-C-ESES; Muris, 2001)—This 8-item subscale was used as a test of concurrent validity for the EADA. Items on this measure follow a Likert-type format from 1 (*Not at all*) to 5 (*Very well*). Higher scores reflect greater perceived capability coping with negative emotions. It has good reliability and validity with an internal consistency of .86 in a Caucasian adolescent sample. The SEQ-C-ESES was translated into Spanish and adapted to Puerto Rican youth ($\alpha = .86$) using the model proposed by Bravo, Woodbury-Fariña, Canino, & Rubio-Stipec (1993).

Children’s Depression Inventory – Spanish Shortened Version (CDI-SSV; Kovacs, 1992)—This 10 item self-administrated scale ($\alpha = .68$) quantifies a wide range of depressive symptoms including disturbances in mood and capacity to enjoy activities, vegetative functions, self-concept, and interpersonal behavior. It contains items that correspond to at least six of the nine DSM-IV-TR symptom criteria for MDD (American Psychiatric Association [APA], 2000).

Procedures

We held meetings with the director and teachers to explain the study purposes, and procedures. After obtaining school authorization, we selected two groups from each grade (8th through 11th), explained the study to potential participants and distributed envelopes containing informed consent/assent forms and a demographic data form. Those who returned signed consent/assent forms completed the three questionnaires in half-hour sessions. If participants scored 9 in the CDI-SSV, their parents were contacted and appropriate referrals were provided.

Data Analyses

After testing the data's suitability for the analysis, we performed an exploratory factor analysis (EFA) with an Alpha Factoring (AF) extraction and an oblique (Direct Oblimin) rotation, using SPSS 15.0. An oblique rotation was selected due to the hypothesized correlation among the factors underlying the EADA. In order to examine to what extent a similar factor structure was obtained across different solutions, as an initial step, we computed 21 solutions combining the seven available extraction methods and three types of rotations (Varimax, Promax and Oblimin). After summarizing the results of these solutions to identify patterns across them, we choose for results presentation a solution that reproduced the same factor loading pattern found after summarizing the 21 solutions. We extracted a two factor solution and selected items with factor loadings .35 in a given factor. Although loadings as low as .30 have been accepted as inclusion criteria by other researchers (Tabachnick & Fidel, 2001), a loading .35 was selected because it produced the best definition among factors (no item loaded into both factors) in this sample, once we opted for the simpler structure solution (two factors) as the optimal one.

We computed Cronbach's alpha coefficients to estimate the internal consistency of the factorial total and subscales scores of the EADA. Pearson correlation was used to assess their concurrent and construct validity by examining their association with scores in the SEQ-C-ESES and the CDI-SSV. Finally, we computed independent *t*-tests to assess gender differences in EADA scores to examine if results were consistent with findings of other studies.

Results

Factor analysis

An EFA was performed on all the EADA items. Inspection of the correlation matrix revealed many coefficients .30. Results of the Bartlett's Test of Sphericity [$\chi^2(378) = 1347.48; p < .001$] and the Kaiser-Meyer-Olkin statistic ($KMO = .82$) supported the factorability of the data. Two meaningful and conceptually distinct factors were identified with eigenvalues of 2.0 or higher (before and after rotation). This two-factor solution explained 37.57% of the variance. EADA items were assigned to the factors based on their loadings. The factors extracted (with variance percents in parenthesis) emerged in the following order: (1) Personal Self-efficacy for Depression (PSED; 29.37%), (2) Interpersonal Self-efficacy for Depression (ISED; 8.20%). The first included 20 items that assessed youth's perceived confidence in using his/her own resources: to manage negative thoughts, depressed mood,

anhedonia, concentration problems and decision making; to voluntarily participate in pleasant activities (alone or with others); and to cope with somatic/functional depressive symptoms (e. g., items 12, 17, 24 and 28). The second factor was comprised by 7 items measuring youth's perceived confidence in expressing his/her feelings to others and eliciting advice, support or help to cope with depressive symptoms.

Items with rotated factors loadings of .35 or more for the two-factor solution are presented in Table 1. Only one item did not meet the inclusion criteria for any factor (Item 19, *Ask for support/advice from other source*, loaded .31 on ISED and .03 on PSED). This item assessed the perceived confidence of youth in asking support or advice from people other than family or friends, such as teachers, ministers, priests, counselors, and psychologists.

The range for the factors loadings obtained was .35 to .70 (Table 1). Most of the loadings (21) for the 27 EADA items that met the inclusion criteria for the factors were of .45. For the PSED factor subscale, the range of the factor loadings was from .36 to .70, while for the ISED factor the range fluctuated from .35 to .64. The correlation between the underlying factors (latent variables) was .39, which supported the use of an oblique rotation. The correlation among observed scores on these factors was .50 ($p < .001$). Three- and four-factor solutions (with eigenvalues >1.50) were also considered but yielded non-interpretable underlying constructs. Furthermore, the Scree test clearly supported two factors. EFA using both Unweighted Least Squares and Principal Axis factoring with Direct Oblimin rotation also produced the same results as AF, with slight variations in loadings size (results not showed) and a .40 correlation among the underlying factors. The AF solution was finally selected because it maximizes the alpha coefficients of the factors and it is considered a correct approach if the researcher is interested in discovering which common factors are consistently found when repeated samples of variables are taken from a population of variables (Tabachnick & Fidel, 2001, p. 613).

Internal Consistency

The alpha coefficients obtained for the factor Total score (TS; 27 items) and subscales of the EADA were .90 (TS and PSED) and .71 (ISED), respectively. Alpha values based on standardized items were .91 and .72, respectively. We also computed alpha coefficients for these scores dividing our sample by gender. Alpha values for boys were .77 (ISED), .87 (PSED) and .90 (TS), while for girls the values ranged from .68 (ISED) to .90 (TS and PSED). Coefficients based on standardized items changed only for the ISED factor (.78 for boys and .69 for girls).

In Table 2 we present descriptive statistics for the 27 items that loaded on the factors, along with their corrected correlations with their factor subscale (CI-SC) and EADA Total factor score (CI-TC). CI-SC values for each EADA factor ranged from .42 to .66 (PSED), and from .36 to .54 (ISED). Almost each CI-TC value for EADA items ranged from .37 to .64, with the exception of item 27 (*Express my feelings/thoughts to parents or friends*), whose coefficient was of .23. The deletion of any item did not improved the internal consistency of EADA factor subscales or TS, although including item 19 on the ISED factor reduced its alpha to .70.

Concurrent and Construct Validity

Consistent with theoretical expectations, a significant and moderate negative correlation ($p = .001$) was obtained between EADA factor scores and adolescents self-reported depression symptoms (CDI-SSV). Specifically, correlations of the CDI-SSV with these scores were of $-.50$ (ISED), $-.63$ (PSED) and $-.66$ (TS). As hypothesized, the correlations of the EADA factor scores with the SEQ-C-ESES were positive and moderate ($p = .001$). These correlations ranged from $.44$ (ISED) to $.72$ (PSED and TS). Interestingly, the correlation of the ISED scores with scores on the only CDI-SSV item that assesses interpersonal aspects of depression (i.e., lack of friends) was $-.32$ ($p = .001$), while the correlation of PSED scores with this item was non-significant ($r = -.14$; $p = .13$). Moreover, the association between ISED scores and scores on item 8 of the SEQ-C-ESES (*How well can you tell a friend that you don't feel well?*) was of $.50$ ($p = .001$), while the correlation of PSED scores with this item was only $.21$ ($p = .02$). This pattern of correlations was also consistent with our expectations, since higher ISED scores should be associated to having a broader social network to ask for support/advice or to tell about one's own feelings, and with the actual youth perceived confidence in doing so.

Females in our sample reported significantly [$t(114) = 2.17$; $p = .05$] higher scores ($\bar{X} = 6.48$; $SD = 2.99$) on the CDI-SSV than males ($\bar{X} = 5.22$; $SD = 3.00$). Given that research literature reflects a moderate and negative correlation between depression and self-efficacy, we expected females to report a significantly lower self-efficacy for depression than males. This expectancy was confirmed when comparing both genders on EADA-TS [$t(114) = -2.89$; $p = .01$] and PSED scores [$t(114) = -4.03$; $p = .001$], but not on ISED scores [$t(114) = 0.81$; $p = .42$].

Discussion

Our results suggested that a two-factor solution, with PSED and ISED as factors, best explains EADA's structure. Although the EADA was developed following four clinical content areas, three of which were modeled from the CBT modules of the manual adapted for Puerto Rican youth (Rosselló & Bernal, 2007), three- and four-factor solutions yielded non-interpretable constructs. EADA items truly assess SED in youth, regardless of the thematic category on which they were modeled. The only latent difference emerges between those items targeting the perceived confidence to use personal resources to cope with situations and symptoms typically experienced when depressed (that is, PSED), and those targeting the confidence to communicate one's own feelings, ask for support, and listening to the advice of a significant other when managing these situations and symptoms (that is, ISED). This is, in fact, consistent with the intention of designing a scale to measure self-efficacy for depression (SED) among Latino youth in a developmentally and culturally appropriate way. Further studies using Confirmatory Factor Analysis, which allows confirming (or not) the structure obtained but using model fit indexes (Hu & Bentler, 1999), should be conducted with a larger ($N = 300$) school-based sample.

Both EADA factors and TS demonstrated appropriate internal consistency. Nevertheless, ISED alpha was somewhat lower. Further studies should evaluate if this was related to sample and/or items characteristics (i.e., sample size or non-clinical nature; lower number

and nature of items on the ISED factor). Because alpha values could be smaller for scales with less than 10 items, Briggs and Cheek (1986) recommend to report also the mean inter-item correlation (MIIC), whose optimal values ranges from .20 to .40. The MIIC for the ISED factor was .27 (Table 2), which compared favorably with MIIC for the PSED factor (.32). Furthermore, an alpha value of .71 is still considered appropriate for research purposes (Nunnally, 1978). It must be acknowledged, in addition, that the ISED factor was composed by items targeting both self-efficacy behaviors related to asking help/support from parents and friends. Indeed, items 26 and 27 targeted both parents and friends at the same time. Using items targeting only one source of support at a time could be a better strategy. It is also possible that targeting all other sources of support (different from family and friends) in a single item (#19) affected the chance of finding a broader ISED factor with higher reliability. For instance, Latino youngsters could be more prone to contact resources closely related with their community (i.e., those from school or church) than those related with traditional mental health services (i.e., psychologists or psychiatrists).

Similar to previous research (Bandura et al., 1999; Comunian, 1989; Ehrenberg et al., 1991; Muris, 2001), we found a significant negative association between self-efficacy and depression. Although it is known that perceived self-efficacy to regulate negative affect has a direct effect on depression (Bandura, Caprara, Barbaranelli, Gerbino, & Pastorelli, 2003), we explored whether our new SED construct has a stronger relation with depression. Similar to Tonge et al.'s (2005) findings, our results suggested a stronger association than that found between youth depression and emotional self-efficacy (Muris, 2001), and affective self-regulatory efficacy (Bandura et al., 2003). Nevertheless, further studies should be conducted to validate the EADA with a large clinical sample of depressed adolescents, as was the case in Tonge and colleagues' (2005) study with the SEQ-DA, to properly compare both questionnaires.

The significant association between the EADA and the SEQ-C-ESES (Muris, 2001) suggests that our new measure properly incorporates the main aspects of Bandura's definition of perceived self-efficacy, in addition to be sensitive to Latino cultural values. The association between the ESES and the PSED factor was stronger than that observed with the ISED one. The SEQ-C-ESES version we used only includes one item addressing youth's perceived confidence to tell a friend that he/she do not feel well. Therefore, that lower association was reasonably expected. Yet, the differential relationship of ISED scores with both the aforementioned item and the CDI-SSV item targeting the size of the friends network, supports its concurrent and construct validity as a distinctive dimension of SED experienced by Puerto Rican youth. Future studies should use other SED measures, such as the SEQ-DA, to further examine EADA's concurrent validity. Moreover, researchers are urged to design new scales incorporating the ISED construct and examine their validity in other Latino and non-Latino youth populations.

Some gender differences were observed. Results confirm the well-known finding of females being more prone to depression than males (APA, 2000). Our findings also showed that females have lower levels of SED (Total score and PSED). This is congruent with other studies that have found that adolescent females doubt their efficacy to manage negative affective states or emotions (Bandura et al., 2003; Muris, 2001). However, this difference

was not found on the ISED factor. We interpret this gender similarity as a consequence of Latino cultural values, such as *familismo* and *personalismo* (Bernal & Enchautequi, 1994; Falicov, 1998). *Familismo* refers to a strong identification and attachment to the family group, with strong feelings of solidarity, loyalty, and reciprocity. *Personalismo* refers to the trust and rapport established with others by developing warm, friendly, and personal relations. Latinos usually value the people who take a personal interest in their lives. Therefore, we argue that both cultural values are not gender-specific. In general, Puerto Rican adolescents and young adults rely on their parents and close friends for solutions, advice and guidance (Bernal & Enchautequi, 1994; Chiang, Hunter, & Yeh, 2004). Future studies should evaluate gender differences in SED (considering PSED and ISED) among youth from diverse backgrounds (including other Latino subgroups).

Almost all items (6 of 7) that loaded on the ISED factor were modeled to target self-efficacy behaviors that were interpersonal in nature. Only one of them (item 25) was designed to target a different content area (activities). Based on our results, it seems that Puerto Rican youth experienced planning activities as a process that most of the time involves significant others. Indeed, it is congruent with Latino values not only to share with others the planning process, but to more probably consider as “recreational” an activity in which interpersonal contact is central (like those targeted on items 5 and 6) than a personal pleasant activity such as reading a book or listening to music alone (like item 4). In fact, activities which suppose social interaction are more prone to be planned by groups. Consequently, planning recreational activities when feeling depressed (item 25) is viewed by Latino youth as a self-efficacy task in which it is important to use others as resources to effectively cope with depression. In contrast, imagining their participation (item 21), maintaining their involvement (items 5 and 6), increasing the frequency of participation (item 23), or actually participating in new recreational activities (item 16) are deemed as processes in which adolescents rely on their own resources for coping (PSED factor).

Other items originally modeled to target interpersonal-related issues (see Díaz-Santos et al., 2008) loaded on the PSED factor (14, 15 and 22). We think that those related to enjoy the company of friends and family (14 and 15) were considered by youth mostly as indicators of overcoming anhedonia (a more subjective process) using personal resources (mostly cognitive and affective). Indeed, those items were not intended to assess if they could ask for the company of another person to cope with depression but rather if they could enjoy (or not) such company. Item 22 (*Relate normally with others*) is also an example of using personal resources to cope with routine relational tasks when depressed. In contrast, the 7 items of the ISED factor were interpreted by youth as reflecting their confidence to ask for external resources when coping with depression. In fact, the ISED construct incorporates Caprara et al. (1999) concept of *self-efficacy to utilize the emotions* to ask for help, not only for resolving a conflict, but also for controlling emotions.

Including items targeting the Latino cultural value of relying on social networks (family and friends) especially as a coping strategy to manage physical/mental health symptoms expands the current definition of SED in youth. As known, Bandura developed the construct of perceived self-efficacy within the context of the dominant Anglo culture, which values more individuality and self-reliance than Latino culture (Cauce & Domenech-Rodríguez, 2002;

Falicov, 1998). The EADA not only includes Bandura's individual-oriented concept of self-efficacy, but also the Latino interpersonal-oriented cultural tradition of asking for help/support when coping with psychological distress (Chiang et al., 2004; Kenny & Stryker, 1996). This tradition is perceived by Latinos as a self-efficacy behavior (not as a weakness), as confirmed by adolescents in the focus group during the EADA development process (Díaz-Santos et al., 2008).

Apparently, the Latino community prefers these informal sources of advice/support instead of seeking professional help first, which they often associate with fear, guilt and shame (Chiang et al., 2004; Falicov, 1998). The low mental health service utilization reported among Latinos (Falicov, 1998), including Puerto Rican children and adolescents (Canino et al., 2004), is consistent with this argument. This cultural preference might help to explain why the only item (#19) targeting sources of support different from family or friends (such as teachers, ministers, priests, counselors, and psychologists), did not load into any factor and obtained the lowest mean (3.10) among all items. Interestingly, one of the items (#9) on the ISED factor (*Get family to help me with activities*) targets (as an example) the instance where the family helps the adolescent to visit a psychologist. This may suggest that Latino youth rely on significant others as resources even to ask for professional help, instead of directly approaching these formal sources of support.

It has been argued that Latinos rely on family support more than do Caucasians (Cauce & Domenech-Rodríguez, 2002; Falicov, 1998). Family and significant others play an important role in the development of self-efficacy in youth (Bandura, 1997). Therefore, a scale that assesses Latino adolescents' perceived confidence to approach significant others while in psychological distress, is not only culturally-sensitive but developmentally-appropriate. Adolescence is a challenging phase where youngsters are creating their perceived self-efficacy while coping with biological, cognitive and emotional changes, as well as more complex social interactions (Bandura, 1997). Their interactions with positive role models or informal counselors help to shape and reinforce adolescents' perceptions related to their goals and their confidence in achieving them. Thus, it is in the youth best interest to be confident to reach these resources for advice, guidance or support, simultaneously increasing both their interpersonal and their personal self-efficacy to cope with life challenges, including depression. In fact, McFarlane, Bellissimo, and Norman (1995) found that family support lowers depression both directly and by strengthening adolescents' belief in their social efficacy.

In addition to the items mentioned previously (14, 15, and 22), it should be noted that the EADA includes two other items that, although modeled to address self-efficacy behaviors related to activities and loaded on the PSED factor, also provide important information about interpersonal relations. Those are items 5 and 6, which relate to continuing with activities they like to do with friends and family, respectively. Taken together, youth reported in those five items their efficacy to keep relating and sharing with others (to avoid social withdrawal), to do it in a healthy way, and to enjoy it, even if feeling depressed, but always using their own resources. This makes those items different from those loading on the ISED factor. Although conceptually and empirically different, taken together, both types of items provide important data about the quality of youth social interactions, their ability and disposition to

maintain them, and the probability to use them as resources for coping with depression. In fact, by including these 12 items (13 if item 19 is considered), the EADA stands as the emotional self-efficacy measure for youth that best emphasize the role of interpersonal issues in the understanding of emotional or affective problems, increasing its developmental adequacy over other available measures.

It is important to clarify that our definition of the ISED factor is not equivalent to the general concept of *interpersonal self-efficacy*. Caprara (2002) and Caprara and colleagues (1999) argued that this construct results from both regulative and social self-efficacies. This latent variable was defined as the perceived efficacy for the management of one's own relations. In contrast, our definition of ISED is more consistent with the one used by Brouwers and Tomic (2001) in the Teacher Interpersonal Self-efficacy Scale. These authors included three interpersonal activities typically performed by teachers: (1) managing student behavior in the classroom, (2) eliciting collegial support, and (3) eliciting principal's support. They indicated that assessing the perceived confidence to seek assistance from colleagues (activities 2 and 3) is crucial because this is a task teachers must attain to achieve excellence in academia. We argue that a measure of perceived self-efficacy in eliciting support from significant others (like ISED) is even more crucial in the case of depressed youth given the supportive role that family and friends can play, operating as safeguards against depression (McFarlane et al., 1995).

This new construct of ISED can be related to social support and/or social self-efficacy. However, it must be acknowledged that they are not identical. *Social support* has been defined as the degree to which a person has a supportive relationship with others (Vieno, Santinello, Pastore, & Perkins, 2007), while ISED refers to the perceived confidence to approach these significant others to request their help and/or support when needed (i.e., when experimenting depression symptoms or situations that can lead to them). Additionally, *social self-efficacy* refers to the perceived confidence in the capabilities to form and maintain social relationships, work cooperatively with others, and manage different types of interpersonal conflicts (Bandura et al., 1999), while ISED targets the perceived confidence to use these social relationships as sources of help or support to cope with the typical experiences associated with depression.

It is known that social self-efficacy and social support act as protective factors against depression (McFarlane et al., 1995). Having a high ISED increases the chance to actually approach social networks for support, thus increasing the possibility of receiving support and reducing depression. In fact, self-efficacy has been found to be a mediator of the effects of social support on psychosocial adjustment in adolescents (Vieno et al., 2007). Future studies with Latino youth should combine the EADA with measures of social self-efficacy and social support to further examine the relation between these constructs.

In summary, the EADA is a valid and reliable self-report scale that follows Bandura's definition of perceived self-efficacy, addressing SED tasks while maintaining sensitivity to the cultural values of Latinos. The EADA may be used as a clinical tool to monitor SED during psychological treatments with Latino youth. This scale could inform clinicians about specific situations where the youngster perceives a low sense of confidence to perform a set

of actions, enabling the increase of the adolescent's SED through the process of restructuring his/her negative cognitions and/or interpretations of situations. Furthermore, ISED items can also inform clinicians about specific inabilities that are interfering with their confidence of approaching a significant other for help/support and further increasing depression severity or duration. This information could be used to encourage adolescents to engage in social relationships with individuals who represent positive role models. Therefore, both PSED and ISED items can provide crucial data to design intervention plans, to further decrease depression symptoms.

Finally, the EADA could be used as a clinical research tool with Latino youth. For example, the scale can be used to evaluate whether SED plays a mediator role in the treatment of youth depression. Future studies could recruit Latino adolescents with high and low levels of SED and evaluate their treatment outcomes. Researchers could evaluate whether a positive treatment outcome for depressed Latino youth is dependable on high pre-treatment levels of SED within both PSED and ISED or if one factor has better predictive validity. In conclusion, the EADA represents the first known attempt to incorporate non-European/American values in an emotional self-efficacy or SED measure to assess the construct as experienced by Latino youth, and provides both a developmental and cultural enhancement of the current SED construct in adolescents.

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Table 1

Factor Loadings of the EADA Items Based on Alpha Factoring Extraction with Oblimin Rotation

EADA Items <i>I am confident that, even if feeling sad, angry/irritable, lonely or discouraged, I can...</i>	Personal Self-efficacy for Depression	Interpersonal Self- efficacy for Depression
1. Reduce or manage negative thoughts	.54	
2. Ask for support or advice from my parents		.58
3. Ask for support or advice from my friends		.42
4. Continue with activities I like to do alone	.56	
5. Continue with activities I like to do with friends	.50	
6. Continue with activities I like to do with my family	.47	
7. Cope with feelings that can affect activities I want to do	.53	
8. Concentrate/pay attention in school	.63	
9. Get family to help me with activities		.40
10. Get friends to help me with activities		.35
11. Take good decisions by myself	.46	
12. Eat normally (properly)	.66	
13. Maintain a positive attitude	.67	
14. Enjoy friends company	.48	
15. Enjoy family company	.43	
16. Carry out new recreational activities	.55	
17. Sleep normally (properly)	.63	
18. Have pleasant thoughts	.65	
19. Ask for support or advice from other sources	---	---
20. Carry out daily activities	.70	
21. Imagine myself carrying out recreational activities	.54	
22. Relate normally with others	.47	
23. Increase frequency of recreational activities	.43	
24. Manage properly moments of agitation/sluggishness	.50	
25. Plan recreational activities		.35
26. Listen to advices from parents and friends		.64
27. Express my feelings/thoughts to parents or friends		.64
28. Overcome fatigue or lack of energy	.36	

Note. Only factor loadings of .35 or more are included. Loadings are based on the Pattern Matrix. Initial eigenvalues for Factor 1 (Personal Self-efficacy for Depression) and Factor 2 (Interpersonal Self-efficacy for Depression) were 8.22 and 2.30, respectively. Eigenvalues after factor rotation were 7.12 (Factor 1) and 3.96 (Factor 2). Items are expressed in key words or phrases that do not represent an authorized English version for use in assessment procedures.

Table 2

Descriptive and Internal Consistency Statistics for the EADA Items and Subscales

EADA Items	<i>M</i>	<i>SD</i>	<i>CI-SC</i>	<i>CI-TC</i>
Personal Self-efficacy for Depression (Alpha = .90; Mean inter-item correlation = .32)				
1. Reduce or manage negative thoughts	3.64	0.81	.536	.493
4. Continue with activities I like to do alone	4.53	.075	.474	.431
5. Continue with activities I like to do with friends	4.27	0.82	.603	.636
6. Continue with activities I like to do with my family	4.17	0.91	.598	.644
7. Cope with feelings that can affect activities I want to do	3.90	0.89	.549	.534
8. Concentrate/pay attention in school	3.80	0.89	.624	.598
11. Take good decisions by myself	4.23	0.73	.424	.417
12. Eat normally (properly)	4.42	0.93	.511	.437
13. Maintain a positive attitude	3.84	0.77	.655	.602
14. Enjoy friends company	4.44	0.73	.560	.572
15. Enjoy family company	4.31	0.87	.523	.555
16. Carry out new recreational activities	3.97	0.98	.595	.591
17. Sleep normally (properly)	4.16	0.93	.510	.454
18. Have pleasant thoughts	4.10	0.90	.571	.526
20. Carry out daily activities	4.34	0.71	.656	.619
21. Imagine myself carrying out recreational activities	4.07	0.91	.497	.473
22. Relate normally with others	4.25	0.77	.449	.444
21. Imagine myself carrying out recreational activities	4.07	0.91	.497	.473
23. Increase frequency of recreational activities	3.60	0.92	.528	.560
24. Manage properly moments of agitation/sluggishness	3.63	0.97	.534	.537
28. Overcome fatigue or lack of energy	3.91	0.89	.422	.449
Interpersonal Self-efficacy for Depression (Alpha = .71; Mean inter-item correlation = .27)				
2. Ask for support or advice from my parents	3.71	1.20	.426	.375
3. Ask for support or advice from my friends	4.25	0.89	.387	.356
9. Get family to help me with activities	4.32	0.90	.480	.452
10. Get friends to help me with activities	4.27	0.89	.379	.403
25. Plan recreational activities	3.74	0.87	.361	.452
26. Listen to advices from parents and friends	4.54	0.72	.538	.367
27. Express my feelings/thoughts to parents or friends	4.23	0.96	.457	.234

Note. *CI-SC* = Corrected Item-Subscale Correlation; *CI-TC* = Corrected Item-Total Correlation.