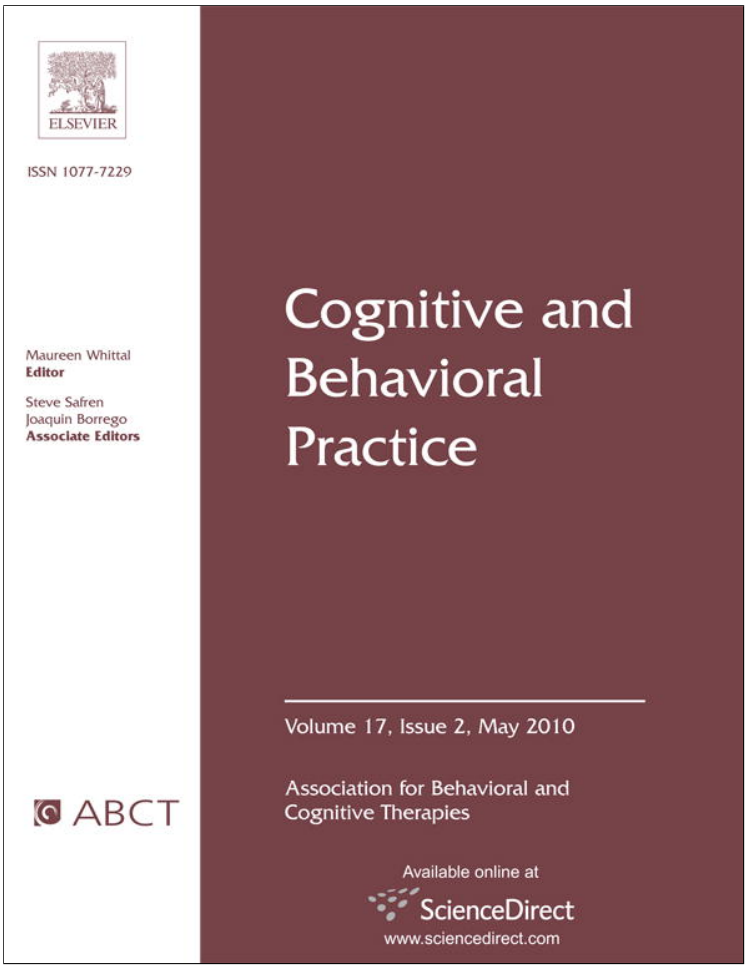

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Developing a Culturally Appropriate Depression Prevention Program: Opportunities and Challenges

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This paper describes the experiences of the first author and his colleagues in the development and implementation of a depression prevention program that specifically targets Latina mothers. Building on the earlier papers that highlight the underutilization of mental health services by Latinos in general, this paper will make the case that the situation is particularly concerning with regards to depression. In addition to the fact that depression is a highly prevalent disorder among Latino adults, the potential consequences for children of parents with depression are significant. Thus, the underutilization of formal mental health services by Latinos makes depression a critical public health problem that calls for creative solutions. One possible solution is the careful development and implementation of prevention programs. Depression prevention programs have some advantages over formal mental health treatment in that they can be offered at a relatively low cost, can be packaged in ways that make them less stigmatizing, and if effective, can reduce the incidence of cases that develop into clinical depression.

This paper will describe the process of developing a novel depression prevention program, with a particular focus on the attention paid to cultural sensitivity. We describe the complexity inherent in defining cultural sensitivity and illustrate in concrete ways its implementation in the development and evaluation of the prevention program. In addition, we explore some of the challenges that emerge when attempting to balance the creation of a program that is culturally sensitive with the demands of rigorous quantitative evaluation.

Depression is one of the most prevalent and disabling psychiatric disorders, and it affects individuals of all racial and ethnic backgrounds. Recent estimates suggest that approximately 16% of the general population will meet criteria for major depression at least once in their lives (Kessler et al., 2005; 2006), with significant numbers experiencing multiple episodes (Boland & Keller, 2002). Moreover, many more will experience clinically significant levels of depressive symptoms that do not reach the threshold for major depressive disorder but are sufficiently impairing to warrant treatment (Kessler, Zhao, Blazer, & Swartz, 1997). The consequences of depression are considerable, producing substantial human suffering and loss of productivity (Greenberg et al., 2003; Wang, Simon, & Kessler, 2003). Moreover, researchers have found that individuals who experience depressive episodes have an elevated risk for future depressive episodes (Boland & Keller, 2002).

At least partly in response to the significant consequences of depression, researchers have developed a variety of efficacious psychosocial interventions for depression (DeRubeis & Crits-Cristoph, 1998). Unfortunately, the research that has documented pervasive healthcare disparities affecting minorities in this country (U.S. Department of Health and Human Services, 2001) has found that Latinos are less likely to utilize formal mental health services than Caucasians (Alegría et al., 2002; Snowden & Yamada, 2005; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999), especially if they are less acculturated or recent immigrants (Alegría et al., 2007; Cabassa, Zayas, & Hansen, 2006; Vega et al., 1999;). Moreover, when Latinos do seek services, they are more likely to prematurely terminate treatment (e.g., Organista, Muñoz, & Gonzalez, 1994; Sánchez-Lacay et al., 2001). This underutilization of mental health services by Latinos is likely the result of many factors; however, it is plausible that the general lack of attention to culture during the intervention development process has led to treatments that are less appealing and less efficacious with Latinos (Bernal & Scharrón-del-Río, 2001; Muñoz & Mendelson, 2005). This possibility, coupled with the rapid growth of the Latino population in the U.S., highlights the importance of devoting resources to the development of novel interventions that can respond to the needs of Latinos presenting with depression.

Prevention programs offer one way to provide mental health services to individuals who might otherwise not

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receive such services. Prevention programs can be advertised in nonstigmatizing ways (e.g., stress management programs), they can be delivered in nontraditional settings (e.g., schools, community centers), and they can be delivered by non-mental-health professionals who receive some training (e.g., teachers, case workers). This flexibility in delivery format is the direct result of the need faced by prevention programs to explicitly consider how to attract participants, as compared with treatment interventions that are more readily sought out by participants in need. Also, because of the flexibility and innovative thinking that accompany the development of prevention programs, they are more readily adapted for specific cultural groups. The ability of culturally adapted programs to enhance the attractiveness and acceptability of interventions, together with the inherently less stigmatizing nature of prevention programs, make culturally adapted prevention programs a potentially important tool in efforts to reduce mental healthcare disparities in the U.S. (Muñoz & Mendelson, 2005).

With regard to depression, there is some evidence that prevention efforts might be particularly effective, both in children and adolescents (e.g., Clarke et al., 1995; Clarke et al., 2001; Gillham, Reivich, Jaycox, & Seligman, 1995) and young adults (Seligman, Schulman, DeRubeis, & Hollon, 1999). Moreover, some research on the prevention of depression in Latinos suggests that these programs have considerable potential to reduce existing symptoms and to prevent their later reemergence (Cardemil, Reivich, Beevers, Seligman, & James, 2007; Cardemil, Reivich, & Seligman, 2002; Muñoz et al., 1995; Muñoz et al., 2007; Vega & Murphy, 1990). Targets of these programs have included Latino middle school children living in urban environments, low-income Latino medical outpatients, mid-life Mexican-American women, and Latina mothers in the postpartum period. One group of Latinos for whom a depression prevention program has the potential to yield considerable benefit is low-income Latina mothers. A variety of studies have found elevated rates of depressive symptoms among low-income Latina mothers (e.g., Bassuk, Perloff, and Garcia-Coll, 1998; Heneghan, Silver, Bauman, Westbrook, & Stein, 1998; Le, Muñoz, Soto, Delucchi, & Ippen, 2004). Moreover, the negative effects of parental depression on childhood adjustment have been well-established in the literature (Downey & Coyne, 1990), and emerging research has extended this relationship to Latinos (e.g., Hovey & King, 1996; Weiss, Goebel, Page, Wilson, & Warda, 1999). Thus, in addition to benefiting the mothers themselves, a prevention program for Latina mothers may also benefit their children.

In a previous article, we described the initial steps of a programmatic research effort to develop the Family Coping Skills Program (FCSP), a depression prevention program for low-income Latina mothers (Cardemil, Kim, Pinedo, & Miller, 2005). In this article, we describe more comprehensively the process of developing a depression prevention program that attempts to attend to cultural sensitivity in a variety of ways. We highlight some of the successes of our efforts, as well as some of the challenges we experienced. Finally, we discuss some of the challenges we are currently experiencing while evaluating this program more rigorously through a randomized clinical trial.

Overview of the FCSP

We have comprehensively described the FCSP elsewhere (Cardemil et al., 2005). In brief, the FCSP is a primarily group-based cognitive-behavioral intervention that draws upon other cognitive-behavioral prevention programs (e.g., Muñoz & Ying, 1993). There are six weekly group sessions, lasting approximately 2 hours each. Each cohort includes 3 to 5 participants. The two primary goals of the group sessions are for the participants to learn a set of concrete skills that can help them more effectively regulate negative emotions, and for the participants to experience a supportive environment through exposure to other mothers who share common experiences. Each session combines the presentation of didactic information with interactive group discussion.

In addition to the group component, the FCSP integrates two separate family sessions into the program. Each participant and one adult family member (e.g., spouse, partner, other supportive adult) meet with the intervention leader twice over the course of the program. The theoretical origins of the family component can be found in the McMaster Model of Family Functioning, a theoretical model that emphasizes the interrelatedness of family members across a variety of domains (Miller, Ryan, Keitner, Bishop, & Epstein, 2000). The primary goals of the family sessions are to introduce the program staff to family members, and to provide some psychoeducation around depression and stress, stress management, and problem-solving.

Summary of Results From Open Pilot Trial

As described in Cardemil et al. (2005), we conducted an uncontrolled pilot trial with the goals of evaluating our ability to recruit participants into the program, and retain them once they enrolled. We were also interested in preliminarily examining change in depressive symptoms over the course of the program. Our results from the initial pilot trial suggest that the FCSP was well-received by both potential and actual participants. The majority of participants were recruited from waiting rooms in health centers, local community organizations, and through word of mouth. Over 75% of those initially approached by study recruiters expressed some interest in participating,

and ultimately about one-third of these enrolled in the project. Of the 33 who enrolled in the open pilot trial, 28 participants (85%) attended at least three of the six group sessions, and 24 participants (73%) attended at least four group sessions. Although the family sessions were less well-attended than the group sessions, approximately 52% of the participants attended at least one family session. Scheduling difficulties were the primary reasons given by participants who were unable to attend either group or family sessions.

With regard to change in depressive symptoms as measured by the Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), there was a statistically significant reduction in depressive symptoms over the course of the program. Much of this difference was driven by the symptomatic improvement in those participants who reported mild to moderate levels of symptoms at baseline, a pattern that is consistent with that reported by other depression prevention programs (e.g., Cardemil et al., 2007; Horowitz & Garber, 2006). In addition, participants who attended at least one family session reported significantly greater reduction in symptoms than those who did not attend any family sessions.

Given the generally positive results from the open pilot trial, we have advanced our research program to more rigorously evaluate the efficacy of the FCSP in a randomized controlled trial, which is comparing immediate participation in the FCSP to a 6-month wait-list comparison condition. In this study, we made several changes to the research protocol in response to our experiences with the pilot study. First, we established more formal inclusion and exclusion criteria. Participants are eligible to enroll if they are female, self-identify as Latina, and have a current status as the primary parental caregiver of at least one child under the age of 12. Exclusion criteria include individuals who are currently depressed or meet full *DSM* diagnostic criteria for a variety of disorders (e.g., substance dependence, psychotic disorders, etc.). Second, in addition to collecting self-report data from participants, we are also including interviewer-based assessments. Moreover, we are conducting assessments through 6 months of follow-up assessment. Third, we have engaged participants more fully in the process of arranging the family sessions. This engagement has included helping participants identify obstacles to setting up family sessions, supporting participants who felt uncertain about how to invite partners, and being particularly flexible in the scheduling of appointments. And fourth, we have developed a measure of cultural competency that mirrors the treatment literature on therapist competency in order to begin to assess the provision of culturally sensitive delivery of the intervention.

To date, we have randomized 68 individuals into the program, and in general, we continue to receive positive feedback from the participants on their experience in the program. For example, participants complete a feedback form after each group session that contains four questions relevant to their experience in the session: (1) How useful and relevant did you find the session? (2) Did you learn any new information in the session? (3) How comfortable did you feel during the session? and (4) How comfortable did you feel talking and sharing your experiences during the session? Scores are rated on a 5-point Likert scale, with higher scores indicative of more positive experiences. Across the 34 participants randomized to the immediate condition, the mean scores were very high (Question 1: $\bar{x}=4.94$, $SD=0.26$; Question 2: $\bar{x}=4.79$, $SD=0.44$; Question 3: $\bar{x}=4.96$, $SD=0.21$; Question 4: $\bar{x}=4.92$, $SD=0.27$). In addition, participants generally provided very positive comments. Many participants commented on the supportive atmosphere. One participant said, "*Todas estamos como en familia* (We are like in a family). It's fun, It's like we've met and shared a lot of the same problems." Another participant reported, "*Me sentí bien pues encontré confianza en todas las participantes como en las que dirigen el grupo* (I felt good, as I found trust among all the participants and among those who lead the group)." Participants also commented on the utility of the skills discussed in the sessions. One participant said, "*Me gustó saber que podemos medir las emociones. El termómetro [emocional] es algo nuevo para mi* (I liked knowing that we can measure our emotions. The [emotional] thermometer is something new for me)." Another participant stated, "*Aprendí como mejor cambiar los pensamientos pesimistas por optimistas* (I learned how to better change my pessimistic thoughts to optimistic ones)."

The positive responses on the feedback form have been mirrored by high levels of acceptability, participation, and retention figures for the group sessions as in the open pilot trial, as well as markedly improved attendance at family sessions (over 75% of participants have attended at least one family session). In addition, we have also been tremendously successful in retaining the participants during the data collection follow-up phase (we have been able to collect 6 months of follow-up data on approximately 90% of the participants). These preliminary data are encouraging; we will soon begin the process of comparing the immediate and wait-list data on depression and other outcome variables.

The Complexity of Cultural Sensitivity

We believe that the generally positive results we have seen so far stem from the fact that the FCSP was developed specifically for low-income Latina mothers. Rather than simply apply an existing prevention program that had been developed for Caucasians, or adapt it for a Latino population, we instead developed a novel program that was built upon traditional cognitive-behavioral

principles. Because low-income Latinos are particularly likely to underutilize mental health services (Kouyoumdjian, Zamboanga, & Hansen, 2003; López, 2002), it was important that this new intervention be appealing, relevant, and useful to the participants. Unfortunately, the literature on integrating issues of culture into traditional therapy orientations is sparse, and there exist different perspectives on precisely what constitutes cultural sensitivity (e.g., Bernal & Saéz-Santiago, 2006; Cardemil, 2008).

In this particular case, in our efforts to conceptualize cultural sensitivity, we decided explicitly to go beyond a traditional definition of culture. Thus, we did not conceptualize culture only as those values, traditions, beliefs, and worldviews that are characteristic of Latinos. Rather, we took a multidimensional approach that conceptualizes culture as a contextual phenomenon that necessarily incorporates gender, socioeconomic status, and the larger systemic barriers individuals encounter in their daily lives. As a consequence, our conceptualization of cultural sensitivity addressed four broad domains. First, we wanted to develop a program that incorporated aspects of Latino culture in the Northeast U.S. (i.e., primarily Puerto Rican, but also Dominican and Central American). This occurred in a variety of ways, including offering participants the possibility of participating in Spanish, integrating important Latino values such as *personalismo, familismo*, and spirituality and religiosity (Gloria, Ruiz, & Castillo, 2004) into various facets of the program, and attending to many culturally relevant life events (e.g., immigration process and stress, concerns regarding acculturation). Second, because our program was developed for Latina mothers, it was critical that issues related to gender be carefully integrated throughout. This attention to gender was accomplished through explicit recognition and valorization of the maternal role, attention to the variable and changing gender roles within and between families, and through the social support provided by the other mothers in the program. Third, we wanted to develop a program that was sensitive and responsive to a variety of issues related to socioeconomic status. In addition to the simple fact that regular economic stress was a significant concern for the majority of participants in our study, many of them indicated concerns with inadequate housing, unsafe neighborhoods, and insufficient medical care. None of these socioeconomic factors are characteristic of Latino culture per se; however, they are strongly associated with the population of Latinos living in the Northeast U.S. and were common among those individuals who participated in the FCSP. And fourth, we wanted to develop a program that could help empower the participants to overcome some of the structural barriers imposed by society on members of disenfranchised groups (e.g., Rothenberg, 2001). In the lives of the participants in our program, these barriers manifested themselves periodically in experiences of overt prejudice and discrimination, as well as more subtly in stories reflecting poor receipt of a variety of social services, including healthcare, welfare, and services for their children.

Thus, our definition of cultural sensitivity meant that the FCSP needed to be able to work with aspects of Latino ethnic culture, life stressors relevant to women in general and mothers in particular, the life experiences often found in urban, low-income neighborhoods, and the sense of disenfranchisement felt by many people of color. Importantly, there was considerable variability across these domains. Specifically, we worked with participants from several different countries of origin, with different immigration stories and histories, and who varied in their adherence to particular Latino customs and traditions. Participants also varied in the extent to which they enacted particular gender roles, were concerned about particular socioeconomic stressors, and had experienced prejudice and discrimination. Thus, developing a culturally sensitive program meant that we had to be flexible enough to work with this naturally occurring variability among our participants across all of these domains.

Cultural Sensitivity and the FCSP

In order to effectively integrate these aforementioned dimensions of cultural sensitivity into a cognitive-behavioral framework, we turned to the emerging literature on cultural adaptations of empirically supported programs. Scholars in this arena have suggested that cultural adaptations can vary in how comprehensively they are incorporated into the program (Castro, Barrera, & Martinez, 2004; Resnicow, Soler, Braithwaite, Ahluwalia, & Butler, 2000). Importantly, these cultural adaptations are not typically viewed as active ingredients that will directly contribute to improvement in the functioning of the client (Lau, 2006; Miranda et al., 2005; Muñoz & Mendelson, 2005). Indeed, Castro and colleagues (2004) point out the tension between fidelity and fit, making the case that cultural adaptations that deviate from the core ingredients of the original intervention run the risk of proving ineffective when implemented.

Our approach was consistent with this perspective in that we focused both on maintaining the centrality of the cognitive-behavioral approach and the application of cognitive-behavioral principles in culturally sensitive ways. Importantly, we believe that the development of a cognitive-behavioral program that is culturally sensitive across the aforementioned dimensions requires a comprehensive integration of cultural sensitivity into all aspects of the program, and not just in the content of the interventions. Further, it is critical that this consideration occurs throughout the development process, and

not just in the final stages. To best achieve this goal, we focused on four dimensions along which to integrate culture: (a) during the design of various structural aspects of the program, (b) in our inclusion of culturally relevant content in each of the sessions, (c) in our attention to culturally sensitive delivery of the program, and (d) in ensuring that the delivery providers were culturally competent. We now describe each in turn.

Cultural Considerations in the Structure of the FCSP

There were several ways in which culture influenced decisions regarding the structure of the FCSP. First, we made an explicit decision to deliver the majority of the program in a group format. The use of a group format had several culturally relevant benefits. Because all of the participants were Latina and most were from low-income backgrounds, they shared a number of life experiences along all of the dimensions of culture noted earlier. These life experiences included stresses associated with immigration and integration into U.S. culture, changing familial gender roles, experiences with prejudice and discrimination, and the lack of financial resources. Importantly, in addition to stressful life experiences, there were many shared moments of success along these dimensions. Because of the personal familiarity with these experiences, the participants have been able to support each other, learn from each other, and provide advice to each other throughout the program.

A second way in which culture influenced the structure of the FCSP was the decision to integrate family sessions into the overall structure of the program. Many researchers have noted the importance of the family in most Latino cultures, particularly with regard to issues of health and sickness (Altarriba & Bauer, 1998; Falicov, 1998; Romero, 2000). Thus, the addition of family sessions allowed us to welcome participants' family members into the treatment process. Importantly, the definition of family was broad, and although participants are encouraged to invite intimate partners if possible, participants are free to invite other important adult figures if preferred. By not being limited to working with husband-wife dyads, we have been able to take advantage of the extended-family structure that is commonly found in Latino families (Falicov, 1998; Gloria et al., 2004). Moreover, significant numbers of single mothers have participated in the program; these participants have invited mothers, siblings, neighbors, and friends to the family sessions.

The third structural decision we made with regard to culture had to do with the choice of language (i.e., Spanish or English) in which we would deliver the intervention. Because Latinos in the United States exhibit a wide range of fluency with both English and Spanish, we decided to give participants the option of enrolling in either an English-language or a Spanish-language version of the FCSP. In addition to ensuring that participants fully understand the content of the program, this flexibility allows us to have participants in groups who can communicate easily with each other. Our experience has been that the participants appreciate this choice, given the dearth of programs that are flexible enough to work in both English and Spanish.

Culturally Relevant Content

In addition to these structural decisions, we also included culturally relevant content throughout the curriculum of both the group and the family sessions. The cognitive-behavioral skills taught in the FCSP are all connected to the central themes of having participants realistically appraise problems that arise in their lives, generate different feasible solutions to these problems, and identify ways in which they can improve their mood even when experiencing chronic stressors that are not easily fixed or improved. The cognitive-behavioral techniques we use to enact these themes include helping participants become more aware of their emotions and moods, better understand and recognize the links among thoughts, feelings, and behaviors, learn to identify unhelpful and helpful cognitions, practice using relaxation exercises to help manage mood, and incorporate pleasurable activities more regularly into their lives.

As with many cognitive-behavioral prevention programs, the curriculum of the FCSP includes life examples, role-play situations, and stories that help make the didactic material more engaging. Throughout our creation and selection of these activities, we took care to make them relevant to the lives of our participants along the dimensions of culture noted earlier. Thus, topics covered include immigration, gender roles, prejudice and discrimination, and financial stress. For example, in one of the group sessions we utilize several role-playing monologues to practice the skill of identifying overly negative thinking and generating more realistic alternative thoughts. One of the monologues depicts a mother who is worried about attending her son's parent-teacher meeting at school because she does not speak English very well. Some of her thoughts include fears that she will be rejected by the teachers and other parents and that her son will be embarrassed of her. Another monologue describes a mother who wanted to give her daughter a *quinceañera* (sweet 15th) party, but could not due to financial difficulties. Her thoughts included concerns that she was failing her daughter as a mother and that every girl needs a 15th birthday party in order to feel special. In this exercise, the group leaders encourage the participants to consider each thought carefully and wonder if there might be

alternative ways of understanding or improving the situation. Through the use of Socratic questioning, participants are encouraged to consider how different thoughts can lead to different emotional and behavioral reactions, some of which are more helpful than others. At the end of the exercise, the group leaders allow space for the participants to comment on their personal familiarity with the scenarios. The group leader guides this conversation to consider how their own personal experiences as Latina mothers living in the U.S. might shape the way that they think about future difficult situations.

In addition to the activities we created for the program, we also encourage participants to share their personal life stories over the course of the program. When working with these life stories, as well as with the examples we provide, we always take care to balance acknowledging the very realistic nature of these concerns with helping participants find opportunities to make small changes that can make them feel better. Importantly, we do not focus on convincing participants that they are engaging in irrational or maladaptive thinking. Rather, together with the group, we incorporate cognitive-behavioral strategies within the context of the participants' lives in order to help them problem-solve in ways that recognize the very real constraints that they face on a daily basis. In addition, we draw on the participants' funds of knowledge and resourcefulness to generate lists of alternative interpretations, problem-focused solutions, and emotion-focused behaviors that are consistent with their cultural practices and past experiences.

We use a similar approach in the family sessions, touching upon a variety of topics relevant to our participants, including how they manage stresses associated with immigration, their low-income status, and parenting their children in a foreign culture. Most often, the participants raise these topics themselves, but when they do not, the intervention leaders gently ask questions designed to promote the relevant discussions.

Culturally Sensitive Delivery of Services

The third area where we pay attention to cultural issues is in the delivery of the program. Intervention leaders attempt to maintain a friendly and relaxed environment that is consistent with the Latino value of *personalismo*. This occurs in a variety of ways in both the group and family sessions, including self-disclosure regarding the intervention leaders' cultural background, attempts to deemphasize the expert role of the intervention leader, and through the provision of food during the sessions.

Importantly, this emphasis on *personalismo* is balanced against the Latino value of *respeto*, and so we are careful to demonstrate respect to all participants through our mannerisms and language (e.g., using the formal *usted* and not the informal *tú* when addressing participants and family members in the second person). Moreover, we demonstrate explicit respect for their role as mother by acknowledging their expert status as mothers and noting that the goal of the program is not to teach them how to be better parents, but to provide a variety of skills that they can incorporate as they choose into their existing repertoire of coping skills.

Another effort to make the program culturally sensitive is through the acknowledgment of our participants' often busy and hectic schedules, due to many competing demands that are reported by many low-income families (e.g., multiple jobs, various appointments with different social service agencies, transportation difficulties). Thus, we are very flexible with scheduling assessment interviews and group meetings, we offer bus passes or taxi vouchers to all participants, and we provide on-site childcare for those participants who need it. We also serve as a source of information for interested participants on a variety of educational opportunities, mental health services, and other social and legal services.

Cultural Competence of Delivery Providers

The fourth area where we focus on cultural sensitivity is in the intervention leaders themselves. In addition to having a racially and ethnically diverse team of intervention leaders, it is critical that the delivery providers be culturally competent in working with the participants in our program. Because cultural competence can be difficult to quantify, we define it as having experience with, and being comfortable interacting with, low-income Latina women. Thus, all of the intervention leaders are either Latino/a or very familiar with Latino culture, spend considerable time working with low-income Latinos, and feel comfortable engaging the participants in the discussions that were relevant to their lives. Moreover, all intervention leaders are fluent in both Spanish and English.

In addition, all intervention leaders participate in both a training program and regular ongoing supervision led by the first author. In the initial training program, the intervention leaders learn how to deliver the program with a high degree of fidelity and cultural sensitivity. Trainees carefully review the manuals for each session, watch videotapes of previous groups led by the first author, and role-play the various sections in each group session. This training continues throughout the implementation of the program and follows a developmental model, as all intervention leaders begin their group work as co-leaders with minimal independent responsibilities and then incrementally progress to independent group leaders.

Complementing this training program is the regular use of a cultural competency measure that we developed

and incorporated into our general therapist competency ratings. The cultural competency measure has five domains, each of which has multiple items upon which the intervention leader is rated. The first domain focuses on the intervention leader's ability to foster a sense of empowerment among the participants, a delicate skill that needs to take into consideration the very real structural and logistical obstacles in the lives of the participants. Thus, intervention leaders attempt to highlight participants' expertise and knowledge and seek opportunities for the participants to help other members of the group (sample item: Group leader makes explicit participants' extensive knowledge and experience in relationships, parenting, coping with difficulties). The second domain addresses the intervention leader's ability to navigate culturally and clinically sensitive moments that periodically arise. For example, we have found variability in views on gender roles in family relationships, with some participants describing cultural values that sanction some gender inequalities in family relationships. Thus, there have been moments when the intervention leaders needed to be able to facilitate a group discussion that was respectful of significant differences in attitudes regarding family relationships (sample item: Group leader demonstrates sensitivity in discussions about gender inequalities in family relationships). Because all the participants are Latina, the intervention leaders need to be familiar with Latino culture and the cultural values of *personalismo* and *respeto* described earlier. Thus, items from the third domain focus on the intervention leader's skills in this area (sample item: Group leader actively creates a sense of *personalismo* in the room, i.e., expresses openness and genuine care, appropriately connects with participants in a warm and familiar manner). Importantly, however, it is also essential that the intervention recognize and manage the cultural heterogeneity among the participants. That is, although all participants have been Latina women living in the Northeast U.S., there exists variability in country of origin, immigration history, and current life circumstances. Moreover, there also exist differences between the intervention leaders and the participants along these same dimensions, and so the fourth domain addresses the intervention leader's skill in managing this variability in a sensitive manner (sample item: Group leader demonstrates the ability to openly acknowledge personal differences among individuals who share a common cultural background). Finally, the fifth domain focuses on the therapist's awareness regarding issues that emerge from the different sociocultural influences on our participant's lives. Some of these influences include immigration, socioeconomic status, racial and ethnic identity, and religious affiliations (sample item: Group leader expresses understanding and awareness of issues particular to immigrant families).

We use this cultural competency measure both as a formal therapist competency form, and as part of the regular group supervision in which all intervention leaders participate. This supervision addresses a variety of issues related to the implementation of the program (e.g., time management, balancing didactic presentation with group discussion, etc), but also regularly includes open discussions on issues related to culture, SES, gender, and power and privilege, particularly as they relate to perceived and/or real differences between intervention leaders and the women in the study.

Challenges of Cultural Sensitivity

As we noted earlier, the preliminary evaluations of the FCSP have been positive. We have been generally successful in recruiting and retaining participants into the study, and we have received considerable positive feedback from the participants. Moreover, some of this positive feedback has explicitly acknowledged the importance of our attention to culture. Participants have noted that they appreciate the opportunity to participate in a program in Spanish, led by intervention leaders who understand their culture, and with other group members who have similar backgrounds and share some common life experiences.

Logistical Challenges

Despite this general success in the development and implementation of the FCSP, we have also experienced a variety of logistical challenges related specifically to the issue of culturally sensitivity. One particular challenge has been the fact that outreach needed to recruit and retain high numbers of participants requires considerable commitment in time and effort. In many ways, this outreach is a fundamental aspect of cultural sensitivity: as noted earlier, many of our participants have significant demands on their time, including working multiple jobs, caring for health concerns of family members as well as their own, and negotiating a variety of social service demands. Other intervention work that has had success in recruiting and retaining low-income participants has also documented extensive outreach efforts (e.g., Muñoz et al., 2007). Thus, the flexibility in scheduling that we included as a critical component of cultural sensitivity requires significant effort to schedule and reschedule appointments, as well as empathy for missed and cancelled appointments. And yet, it is likely that our status as a research institution affords us more flexibility in scheduling than community-based mental health and social services organizations. Thus, if considerable and consistent outreach is necessary for successful delivery of this program, then it may be difficult for less time and resource-rich community organizations to implement such programs.

Thus, if the results from our randomized controlled trial suggest that the FCSP is efficacious in reducing depressive symptoms, then future research would do well to explore how to design and implement prevention programs so as to overcome or reduce the impact of this issue. One possibility might be the use of open group formats that allow participants to join the group when they are able, and does not present material in a cumulative fashion (e.g., Friedman et al., 2005). Another possibility that merits investigation is supplementing in-person group meetings with information provided via different means (e.g., bibliotherapy, Internet). Other researchers have documented considerable success in the arena of Internet delivery of interventions (Muñoz & Mendelson, 2005). Both of these possibilities would likely have to be investigated in the context of effectiveness research designs that specifically investigate questions of effectiveness in less controlled environments.

Theoretical and Empirical Challenges

In addition to these logistical challenges, our experience of conducting a randomized controlled trial of the FCSP has also raised to our awareness an interesting issue regarding the balancing of two very different epistemological traditions: the idiographic, *emic*, and occasionally social constructivist perspectives underlying the literature on cultural sensitivity and the nomothetic, *etic*, and generally positivist perspectives that form the backdrop of much of the literature on evidence-based paradigms like the empirically supported treatment movement (Hall, 2001; La Roche & Christopher, 2008). A comprehensive discussion of the tension between these two paradigms is beyond the scope of this paper, but one way in which we have struggled with these two different perspectives on knowledge has been with our desire to operationalize and assess cultural sensitivity. Although we feel that we defined cultural sensitivity clearly in both conceptual (i.e., ethnic, gender, socioeconomic, and societal structure considerations) and dimensional ways (i.e., incorporating cultural sensitivity into the structure of the program, the content of the material, the delivery of the program, and the behavior of the providers), it has nevertheless remained a challenge to use our definitions to formally assess cultural sensitivity.

Put another way, an ongoing question for us has been how to evaluate the extent to which we were successful in our efforts to make the FCSP culturally sensitive. Along with participant feedback data, the relatively good recruitment and retention numbers suggest that we have been at least somewhat successful in this regard. However, at this stage, it is impossible for us to know which of the various aspects of cultural sensitivity was most important, and which ones may be less so. For example, was our selection of culturally relevant material appropriate for the specific participants in our intervention? Did we include a sufficient amount of this material, and how much did it really matter that we included this information? Perhaps some of the other dimensions of cultural sensitivity were more important (e.g., structural considerations like the inclusion of family sessions, use of culturally competent intervention providers).

Even when we restrict our assessment of cultural sensitivity to the behavior of the intervention leaders, we encounter challenges. Specifically, when we examine data from the cultural competency measure, we find little variability among the intervention leaders in the evaluations of their cultural competence and sensitivity. Although the use of our cultural competency measure has been useful in training the intervention leaders, the lack of variability in the measure makes it impossible for us to quantitatively measure the relationship between cultural competency and outcome in our study. It is likely that more variability exists across the population of potential intervention leaders; however, it is also plausible that only those individuals who are already highly culturally competent or who have the ability to quickly become culturally competent would be the ones selected or interested in participating in the delivery of a culturally sensitive program.

The more general questions that emerge from our experience include: Is it possible for the field to evaluate the extent to which investigators are successful in their attempts to develop culturally sensitive programs? Can we assess therapist cultural competency along a continuum or is it best conceptualized categorically? These questions are important, since it is likely that some interventions are more culturally sensitive than others, and that some therapists are more culturally competent than others. For a field that values quantitative, empirical assessment, these are difficult questions with no clear answers, and as such, highlight the limits of the positivist perspective on what constitutes evidence. In some regards, these questions may be unfair, since we do not tend to ask similar questions about measuring how "behavioral" or "cognitive" a particular intervention may be. However, insofar as one of the assumptions of this literature is the belief that culturally sensitive interventions are more likely to recruit and retain participants, then those of us interested in developing interventions that incorporate culture would do well to consider how we can evaluate the extent to which cultural sensitivity was successfully implemented. Perhaps we will need to turn to nonquantitative methods of evaluation, drawing on the qualitative perspectives and methodologies that exist in anthropology, sociology, as well as feminist perspectives on psychology. However, quality research that incorporates both quantitative and qualitative methods is complex (e.g., Creswell & Plano Clark, 2007) and so will likely require the development of novel approaches particularly for intervention research.

Our experience with the development of the FCSP has led us to view these logistical and theoretical challenges as inextricably intertwined with any attempt to incorporate issues of cultural sensitivity into traditional intervention research. In particular, because culture sensitivity needs to be flexible enough to address contextual variability (i.e., gender, socioeconomic status, minority status) as well as be infused throughout the intervention (i.e., structure, content, delivery, and deliverers), it is difficult to assess one area in isolation. Moreover, each of the different domains of the intervention are interrelated such that the structural framework of the intervention (theoretical design, content material, supervision and training) enables and supports the development of culturally competent delivery and culturally competent therapists. For example, it is likely that requiring the intervention leaders to explicitly work with the participants' busy schedules and transportation needs helps the intervention leaders develop empathy and concern regarding accommodating those needs. As such, it is likely that a multilayered, multimethod approach is required to assess such a complex phenomenon. Given the changing demographics of the U.S., and the increased attention to the importance of culture in mainstream psychology, we anticipate that these issues will become increasingly salient for researchers and clinicians alike. Nevertheless, these challenges have not diminished our enthusiasm for the overall positive experience we have had during the development and evaluation of the FCSP. In our view, culturally sensitive prevention programs can play an important role in helping to provide exposure to mental health services to many individuals who may not typically seek it out. Thus, research that investigates how best to integrate cultural sensitivity with traditional prevention models will likely contribute to the goal of eliminating the healthcare disparities that affect so many individuals today.

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