

Developing a Culturally Appropriate Depression Prevention Program: The Family Coping Skills Program

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Depression is a disorder that can have particularly deleterious effects on individuals from racial/ethnic minority and low-income backgrounds. Culturally appropriate prevention programs offer a way to provide accessible and effective mental health services to these underserved populations. The authors introduce the Family Coping Skills Program (FCSP), a novel depression prevention program developed specifically for low-income Latina mothers. The authors present the theoretical underpinnings of the FCSP and describe their efforts to make the program culturally appropriate and to enhance recruitment and retention of participants. Initial outcome data from an uncontrolled trial were promising and support continued development and evaluation of the FCSP and other similar programs.

Keywords: depression, prevention, culture, Latino

Depression is a mental disorder that affects individuals of all racial, ethnic, and socioeconomic backgrounds. It has been estimated that up to 17% (Kessler et al., 1993) of the general population will meet criteria for major depression at some point in their

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lives. The consequences of major depression are significant, producing substantial human suffering and loss of productivity (Greenberg, Stiglin, Finkelstein, & Berndt, 1993).

Individuals from racial/ethnic minority and low-income backgrounds are particularly vulnerable to the effects of depression for two primary reasons. First, prevalence rates of depression are elevated in both racial/ethnic minority groups (Roberts, Chen, & Solovitz, 1995; Vega & Rumbaut, 1991; Vera et al., 1991) and among low-income populations (e.g., Bruce, Takeuchi, & Leaf, 1991; Golding & Lipton, 1990; Vega et al., 1998). Second, many individuals from racial/ethnic minority and low-income backgrounds underutilize (Kouyoumdjian, Zamboanga, & Hansen, 2003; López, 2002; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999; Wells, Klap, Koitke, & Sherbourne, 2001) and prematurely terminate (e.g., Organista, Muñoz, & Gonzalez, 1994) mental health services. Therefore, mental health services that are more accessible and relevant to the lives of low-income and racial/ethnic minorities may yield important benefits to increasingly large portions of the population.

Prevention programs offer one way to provide mental health services to individuals who might otherwise not 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). Moreover, emerging research on the prevention of depression in Latinos suggests that these programs can be effective in reducing existing symptoms and preventing their later emergence (Cardemil, Reivich, & Seligman, 2002; Muñoz et al., 1995; Vega & Murphy, 1990).

This article presents the first stage in a programmatic research effort to develop a depression prevention program for low-income Latina mothers: the Family Coping Skills Program (FCSP). We begin by explain-

ing our rationale for focusing on low-income Latina mothers. Next, we present the theoretical underpinnings and structural framework of the program, describe our efforts to make the program culturally appropriate to the participants, and discuss our efforts to recruit and retain participants in the FCSP. Finally, we present some initial outcome data from an uncontrolled trial regarding recruitment and retention rates, along with some preliminary data relating to changes in depression symptoms in the participants.

Rationale for Working With Low-Income Latina Mothers

There are several compelling reasons to develop depression prevention programs specifically for low-income Latina mothers. First, the Latino population in the United States has grown tremendously over the past 10 years. The recent 2000 U.S. Census noted that the Latino population grew 58% since 1990, thus becoming the largest ethnic minority group in the United States, with an estimated population of over 35 million (U.S. Census Bureau, 2003). This population surge has not been matched by comparable growth in economic opportunities, however. Some researchers have posited that Latinos are the most socioeconomically disadvantaged group in the United States (Santiago, 1992), a notion supported by the fact that in 1995 Latino households were the only ethnic group with a declining median income (Bassuk, Perloff, & García-Coll, 1998). Not surprisingly, some researchers have found elevated risk for depression among Latinos (e.g., Hovey, 2000; Myers et al., 2002). These characteristics, coupled with the fact that Latinos underutilize formal mental health services, especially if they are less acculturated or recent immigrants (Miranda, Azocar, Organista, Muñoz, & Lieberman, 1996), highlight the role that prevention programs could play in the future.

Second, some researchers have found that low-income Latina mothers are particu-

larly vulnerable to experiencing depression and its associated symptoms. Bassuk et al. (1998) found that low-income Puerto Rican single mothers were more than twice as likely as similar low-income Caucasian mothers to report a current episode of major depression. Heneghan, Silver, Bauman, Westbrook, and Stein (1998) reported high levels of depressive symptoms in over 25% of their sample of inner-city Latina mothers. This risk for depression increases when co-occurring family problems exist, with "case-ness" rates of depression ranging up to 30% in some samples of Latina mothers (Blacher, Shapiro, Lopez, Diaz, & Fusco, 1997). A prevention program that specifically targets depression would be especially useful for these high-risk parents.

Third, a depression prevention program for mothers could positively influence the development of the children in the family, given the effects of parental depression on childhood adjustment (Downey & Coyne, 1990). Emerging research has also linked parental depression, family dysfunction, and childhood depression in Latinos. For example, in a study assessing risk for the development of depression and social withdrawal in Latino children, Weiss, Goebel, Page, Wilson, and Warda (1999) found that the greatest risk was for those children whose families relied more extensively on internal coping strategies, such as passive resignation, and whose parents were dissatisfied with their family's interactions. In addition, Hovey and King (1996) found that Latino adolescents who perceived family dysfunction reported significantly higher depressive symptoms than Latino adolescents who did not. Thus, a prevention program for Latina mothers may also benefit their children.

The FCSP: Theoretical Underpinnings and Structural Framework

Despite the potential benefits that depression prevention programs could offer this population, few researchers have attempted

to develop depression prevention programs for low-income Latinos. There are likely many reasons for this, including the fact that it can be very difficult to recruit and retain low-income Latinos into intervention research (e.g., Miranda et al., 1996). In addition, many intervention researchers may not know how to develop a culturally relevant program for low-income Latinos. In response to these difficulties, we developed the FCSP as a novel depression prevention program specifically for low-income Latina mothers. Our hope was that the FCSP would be culturally appropriate, that it would be able to overcome some of the recruitment and retention difficulties encountered by others, and that it would prove interesting and beneficial to the participants.

Like the majority of the depression prevention programs described in the literature (Cardemil & Barber, 2001; Gillham, Shatté, & Freres, 2000), the FCSP is primarily a group-based intervention. One of the specific innovations that we brought to the development of the FCSP, however, is the inclusion of family sessions in which each participant and an adult family member meet with the group leader. In addition, we devoted considerable attention to issues of cultural relevance and sensitivity in the development of the FCSP. Thus, through the integration of culturally sensitive group and family sessions, the FCSP aims to bolster the resiliency and coping ability of its participants so they can better handle both ordinary and difficult life circumstances.

Theoretical Underpinnings

The group sessions, which represent the primary aspect of the program, are cognitive-behavioral in origin and draw on both the Depression Prevention Course (Muñoz & Ying, 1993) and the inner-city version of the Penn Resiliency Program (Cardemil et al., 2002). The decision to deliver the FCSP in a group format was based on several factors. First, researchers have demonstrated that group cognitive-behavioral therapy treat-

ment programs for depression can be as efficacious as individual psychotherapy (McDermut, Miller, & Brown, 2001). Second, several researchers have suggested that group therapy may be a particularly appealing and possibly effective therapeutic modality for working with Latinos (Delgado & Humm-Delgado, 1984; McKinley, 1987). Finally, there is evidence suggesting that group cognitive-behavioral therapy can be a cost-effective treatment option (e.g., Antonuccio, Thomas, & Danton, 1997).

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 family component was included in the FCSP in light of strong evidence regarding the role of family functioning in the development and maintenance of depression (Keitner & Miller, 1990). We believe that including family members in the FCSP is particularly useful with Latinos, given that researchers have consistently highlighted the importance of the family in most Latino cultures (e.g., Falicov, 1998; Padilla & Lindholm, 1984). Many have argued that both health and sickness are family affairs in Latino culture, and therefore family members should be included and welcomed into the treatment process as a testament to their interconnectedness (Altarriba & Bauer, 1998; Romero, 2000).

Structural Framework

As it is currently designed, the FCSP consists of six group sessions and two family sessions. Prior to enrollment, all potential participants attend an assessment/orientation session in which they meet individually with the group leader to assess their suitability for the group. The FCSP group begins meeting when a sufficient number of participants (between 5 and 8) have been recruited and have completed this assessment process.

GROUP SESSIONS. The six weekly group sessions last 90 min each and are designed to accommodate 3 to 5 adults. There are two primary goals of the group sessions. First, participants learn a set of concrete skills that can help them more effectively regulate negative emotions, including anxiety, sadness, and anger. Some of the cognitive skills include how to accurately identify and understand connections between their emotions and thoughts (Session 1–2), how to evaluate their beliefs (Session 3), and how to replace unrealistic pessimistic thoughts and beliefs with more accurate interpretations of their problems (Session 4). Some of the behavioral skills covered in the group sessions include relaxation skills (Session 5) and pleasant activity scheduling (Session 6). Throughout the six sessions, participants also receive information regarding effective parenting skills drawn from a well-established parent-training program (Webster-Stratton, 1992), although this is not the central focus of the sessions.

The second main goal of the group sessions is to provide a supportive and normalizing environment through exposure to other mothers who share common experiences. Discussing the stresses associated with child rearing while learning from other parents can be both a supportive and an informative experience.

During each session, the group leader balances presentation of didactic information with facilitation of interactive group discussion. This balance is accomplished through structured sessions, with specific time limits guiding the group leader through the various elements of each session. Built into this structure is ample time for group members to interact with one another, share individual stories and experiences, and provide emotional support as needed. For example, it is common for one group member to ask the group leader for suggestions on issues like time management, child rearing, or family problems. In general, the group leader attempts to get the other group members to offer their own experiences with similar situations, encour-

aging brainstorming and social support. We have found that enlisting group members as coexperts in managing their lives as Latina mothers helps increase their sense of personal efficacy. In addition, it increases members' commitment to the group while at the same time increasing the social and emotional support they receive from the other group members.

FAMILY SESSIONS. The two family sessions last 1 hr each and provide an opportunity for the participants to have important conversations with adult family members that they might otherwise not have. The primary goal of the first family session is to introduce the family member to the FCSP and the group leader. As with any prevention or treatment program, it is important that family members and friends have the opportunity to address any anxieties or questions they may have regarding the program and their family member's participation in it. For example, some of the participants' spouses have expressed concern that the FCSP is a forum in which the group members criticize them. To alleviate these and any other concerns, the leader asks the group member to explain as best as she can the purpose of the FCSP and some of the activities and topics that have been covered in the group sessions. The leader then answers any other questions from the family member and explains the goals of the FCSP research program.

The second goal of the family sessions is to provide some psychoeducation around depression and stress, stress management, and problem solving. When time permits, participants are also encouraged to personalize the discussions around their own life situations. While dramatic change in the family system is unlikely to happen in two family sessions, we have found that small improvements in communication, problem solving, and emotional support can take place following even minimal amounts of family treatment (e.g., Friedman, Cardemil, Gollan, Uebelacker, & Miller, 2003).

The FCSP: A Culturally Appropriate Program

We believe that one of the strengths of the FCSP is that it was developed specifically with low-income Latina mothers in mind. Because this population is particularly likely to underutilize mental health services (Kouyoumdjian et al., 2003; López, 2002), we wanted the FCSP to be appealing, relevant, and useful to our participants. To create a culturally appropriate program, we emphasized the following four elements: (a) flexibility with respect to language choice, (b) culturally relevant content in the program material, (c) culturally sensitive delivery of the program, and (d) multicultural competence of the delivery providers.

Flexibility With Respect to Language Choice

One of the most important decisions that we faced when developing the FCSP was the choice of language (i.e., Spanish or English) in which we would deliver the intervention. Latinos in the United States exhibit a wide range of fluency with both English and Spanish, and having a group in which participants were able to understand each other was obviously important. Ultimately, we decided to give participants the option of enrolling in either an English-language or a Spanish-language version of the FCSP, because we wanted to be able to provide services to women regardless of their preferred language. We found that both our participants and the leaders of community organizations who learned of our program welcomed this choice, given the dearth of programs that are flexible enough to work in both English and Spanish.

Culturally Relevant Content Material

Next, we aimed to weave culturally relevant content throughout the curriculum of both the group and the family sessions. We chose life examples, role-play situations, and sto-

ries that we have found to be particularly relevant to the lives of low-income Latina mothers. For example, some of the topics of discussion included immigration stories, family adjustment to a new cultural environment, as well as experiences with prejudice and discrimination. In addition to providing this material ourselves, we also allotted time for the participants to share their own relevant life stories. We found that this discussion time allowed many group members to experience support and validation with regard to these life experiences for the first time. We took a similar approach to the family sessions, touching on a variety of topics relevant to our participants, including how they manage stresses associated with immigration, their low-income status, and having their children grow up in a foreign culture. Most often, the participants would raise these topics themselves, but when they did not, the group leaders would gently ask questions designed to promote the relevant discussions.

Culturally Sensitive Delivery of Services

In addition to including culturally relevant content in the material, we also wanted to make the program feel welcome and safe for the participants; therefore, we spent considerable time ensuring that the process in which the program was delivered was culturally sensitive. One particularly important focus was an explicit acknowledgment of our participants' often busy and hectic schedules, because of many competing demands that are reported by many low-income families (e.g., multiple jobs, various appointments with different social service agencies, transportation difficulties) as well as the fact that all participants were parents of school-age or younger children. This acknowledgment was established from the beginning, as the group leaders make it a priority to schedule the assessment interviews around the availability of the potential participant rather than the other way around. In addition, those participants who reported trans-

portation difficulties were offered bus passes or taxi vouchers to ease the cost of their travel. We also provided onsite child care for those participants who needed to bring their children with them to treatment sessions.

Group leaders also attempted to create and maintain an explicitly friendly and relaxed environment rather than a formal or professional one. One way in which this was accomplished during the initial interview was through self-disclosure regarding the group leaders' cultural background, along with a brief discussion about the goals and hopes for the project. We have found that many Latinos are inherently curious about other Latinos' personal backgrounds and that considerable interpersonal connection occurs through this exchange of information. Another way that the group leaders attempt to maintain a friendly and relaxed environment is through a deemphasis of the "expert" role of the group leader. Thus, throughout the program, the group leaders explicitly acknowledge that the participants are themselves parenting experts who can both learn and help each other over the course of the group. This shifting of some of the expert role to the participants contributes to a sense of shared group ownership among all of the participants.

We paid particular attention to culturally sensitive process in the development of the family sessions. For example, the FCSP explicitly encourages the participants to invite any important adult figure. By not being limited to working with husband-wife dyads, the FCSP takes full advantage of the extended-family structure, which others have highlighted as important in Latino families (Altarriba & Bauer, 1998). In addition, considerable care was taken to express a welcoming attitude and to demonstrate respect for the family and to the family member in the session (e.g., using the formal *usted* and not the informal *tú* when addressing participants and family members in the first person). Extra time was devoted to addressing any questions or concerns that the family members may have had. Given the importance of the family in Latino culture, we felt

that it was important to make a concerted effort to help the family members feel comfortable with the program and the group leader.

Cultural Competence of Delivery Providers

In addition to delivering the program in a culturally sensitive manner, we also emphasized the cultural competence of the delivery providers. While cultural competence can be difficult to quantify, we defined it as having experience with, and being comfortable interacting with, low-income Latina women. In this regard, the group leaders were familiar with Latino culture, had spent considerable time working with both low-income and racial/ethnic minority individuals, and felt comfortable engaging the participants in the discussions that were relevant to their lives. Moreover, the group leaders and two of the three coleaders were fluent in both Spanish and English.

An additional important point is that the FCSP research team has been very racially and ethnically diverse, as all of the leaders and coleaders of the group and family sessions were members of racial/ethnic minority backgrounds. We believe strongly in the importance of racial/ethnic diversity in staff that interacts with individuals from racial/ethnic minority backgrounds. On several occasions, participants commented to us that they appreciated the diversity of the delivery providers, noting how unusual it is for them to interact with non-Caucasian health providers in their daily lives.

Although some of these culturally sensitive process elements may be implemented to various degrees in groups with non-Latino populations, we emphasized them because of the importance that Latinos place on personal relationships (known as *personalismo* in Puerto Rican culture; Comas-Diaz, 1985). It is difficult to quantify the extent to which we were successful in forming personal connections with the participants; nevertheless, we take these nonspecific elements seriously and must at some

point consider their role when evaluating the efficacy of the FCSP.

Goals of Present Study

We developed the FCSP with the hope that our combination of six cognitive-behavioral group sessions and two family sessions, delivered in a culturally appropriate manner, would be appealing and useful to our participants. Our first step in evaluating our ability to meet these goals was to recruit a small number of Latina mothers to participate in the FCSP in the context of an uncontrolled trial. We now present feasibility data relating to recruitment of participants into the FCSP, as well as retention data of those who eventually enrolled in the program. In addition, we present preliminary data relating to changes in depression symptoms over the course of the program.

Method

Procedure and Participants

Participants were recruited from a variety of sources, including waiting rooms at a free pediatric clinic, a local community health center, local community organizations, and word-of-mouth. Although the details varied slightly depending on the recruitment source, our general recruitment procedures were similar: We approached participants, provided a brief explanation of the program to gauge interest, and then gave more detailed information to those who desired it.

Those individuals who agreed to participate in the program were then given an individual assessment appointment. The purpose of the individual assessment was to welcome the participants to the program, answer any questions or concerns they might have, and assess their suitability for the program. In addition, participants completed several measures during this appoint-

ment (see below). Esteban Cardemil and Saeromi Kim led the group and family components of the FCSP. There were eight iterations of the FCSP: Two of the cohorts were held in English, and six were in Spanish.

Assessment Measures

Participants completed self-report measures regarding depression symptoms and acculturation level prior to the first assessment session and then subsequent to the final group meeting. Participants were given the option of completing the following measures in either English or Spanish.

BECK DEPRESSION INVENTORY. The Beck Depression Inventory (BDI; Beck, Ward, Mendelson, Mock, & Erbaugh, 1961) is a 21-item self-report measure of depressive symptoms. Scores range between 0 and 63, with higher scores indicative of more depressive symptoms. Researchers have reported reliability coefficients range between .70 and .95; correlations with clinical ratings of depression range from .55 to .96 (Beck, Steer, & Garbin, 1988). We found high internal reliability for the BDI in our sample, for both the English ($\alpha = .90-.92$) and Spanish versions ($\alpha = .90-.94$).

MARÍN ACCULTURATION SCALE. The Marín Acculturation Scale (Marín, Sabogal, Marín, Otero-Sabogal, & Perez-Stable, 1987) is a commonly used measure that has demonstrated good psychometric properties and correlated highly with generation, length of residence, and age of arrival in the United States. Scores range between 1 and 5, with higher scores indicating more acculturation. We found good internal reliability with this measure ($\alpha = .91$).

Results

We had two primary goals for this stage in our development of the FCSP. Given the

difficulty that other researchers have had in both recruiting and retaining low-income and racial/ethnic minority individuals into intervention research, our primary goal was to evaluate the feasibility of recruitment of participants, as well as determine how acceptable the FCSP would be to those participants who expressed interest in the program. We also were interested in gaining some preliminary information regarding the efficacy of the program, along with ensuring that the program did not produce any detrimental effects (e.g., worsening of depressive symptoms). Thus, in addition to recruitment and retention information, we also present some preliminary information on depressive symptoms.

Baseline Assessment

Of the 33 participants who enrolled in the program, 21 reported combined family incomes below \$25,000 per year, and 6 reported income in the \$25,000–\$50,000 range. Six participants provided no income information. Puerto Rico ($n = 20$) and the Dominican Republic ($n = 4$) were the most common countries of origin indicated by the participants. Seventeen of the women reported being married or in a committed relationship, 7 indicated they were divorced or separated, and 5 reported being single. The most common religious affiliation was Catholicism ($n = 20$), with the remainder listing other Christian denominations as their religious affiliation. Ten of the participants indicated that they were currently employed, and 7 reported being currently unemployed. Six women stated that they were full-time homemakers, and 2 were currently students.

At baseline, the mean acculturation score for the overall sample was 2.20 ($SD = 0.71$), indicating that the majority of our participants tended to speak and read more often in Spanish than in English, socialize with other Latinos more than with non-Latinos, and prefer Latino cultural activities more than non-Latino cultural activ-

ities. With respect to depressive symptoms, the mean BDI score at baseline was 14.41 ($SD = 10.82$), indicating mild levels of depressive symptoms. There was no significant correlation between depressive symptoms and acculturation, nor was there any significant correlation between depressive symptoms and any of the demographic variables (e.g., age, socioeconomic status, number of children, or education level).

Feasibility of Implementing the FCSP

RECRUITMENT AND ENROLLMENT. The initial recruitment process was well received. Over 75% ($n = 103$) of those approached expressed some interest in participating. The vast majority of those who declined further information indicated that they had no free time to participate in any activities. Of the 103 who expressed interest in participating in the program, 47 ultimately attended the initial assessment session. Fourteen of these women were unable to continue their participation after the initial assessment session because of unexpected schedule changes, leaving a final sample of 33 women who enrolled in the project.

TREATMENT RETENTION. Four women dropped out after one or two group sessions because of unexpected changes in their schedules. One participant indicated that she did not feel comfortable participating in the group activities and withdrew from the program after two group sessions. The remaining 28 participants (85%) attended at least three of the six group sessions, and 24 participants (73%) attended at least four group sessions.

The family sessions were less well attended than the group sessions. Of the 33 participants, only 5 participants (15%) attended both family sessions, although 17 participants (52%) attended at least one family session. Scheduling difficulties were the primary reasons given by participants who attended one but not both family sessions. Reasons given for not attending any

family sessions were slightly more varied and included the primary partner being unwilling to attend, participants being socially isolated and having no one to invite, and schedule conflicts. Attendance at family sessions was particularly low among participants in the first two cohorts of the FCSP (e.g., only 40% of participants attended one family session) and increased over the final six cohorts (e.g., 56% of participants attended at least one family session).

Change in Depressive Symptoms

In this section, we present preliminary data on change in depressive symptoms reported by the participants over the course of the FCSP. We conducted paired t tests to examine change in depressive symptoms on the BDI from baseline to postintervention and used Cohen's d to determine the effect size of this difference. Cohen's d is calculated as the difference between the baseline and postintervention means divided by the pooled standard deviation of the two means (Cohen, 1988).

We focus our analyses on those participants ($n = 24$) who attended at least four group sessions and label these participants as *completers* of the FCSP. The mean BDI scores for this group of participants dropped from 11.21 points ($SD = 7.66$) at baseline to 7.21 points ($SD = 7.06$) at postintervention, a reduction of 4.00 points ($SD = 9.20$). This difference was statistically significant, $t(24) = 2.13$, $p < .05$, $ES = 0.54$, and represented a mean reduction of 36% of symptoms from pre- to postintervention. In addition, 13 of these participants (55%) reported reductions in BDI scores greater than 50% of their preintervention scores.

More careful examination of these data reveals a difference between those participants ($n = 11$) who were relatively symptom free at baseline (BDI < 10) and those participants ($n = 13$) who reported mild to moderate depressive symptoms at baseline (BDI > 10). The participants who reported mild to moderate depressive symptoms at base-

line demonstrated a statistically significant greater reduction in depressive symptoms over the course of the FCSP than the participants who were symptom free at baseline, $t(22) = 2.52, p < .05, ES = 1.04$. This between-groups difference was due to the fact that participants who were symptom free at baseline showed almost no change at all in their symptoms over the course of the intervention (BDI scores at baseline: $M = 4.27, SD = 3.13$; BDI scores at postintervention: $M = 4.91, SD = 6.55$), whereas the participants who reported mild to moderate depressive symptoms at baseline demonstrated a substantial drop in depressive symptoms over the course of the FCSP (BDI scores at baseline: $M = 17.08, SD = 4.79$; BDI scores at postintervention: $M = 9.15, SD = 7.14$). The reduction in depressive symptoms reported by the mild-to-moderate group represented a 46.5% mean reduction in symptoms.

We also noted a difference in BDI scores between those participants who did not attend any family sessions ($n = 8$) and those who attended at least one family session ($n = 16$). The mean BDI scores for the participants who did not attend any family sessions actually increased slightly over the course of the FCSP, from 10.75 points ($SD = 9.53$) at baseline to 10.88 points ($SD = 8.36$) at postintervention, although this difference was not statistically significant. This mild increase was in marked contrast to the reduction in BDI scores reported by the 16 participants who attended at least one family session. These participants reported a reduction of 6.06 points ($SD = 8.11$), from 11.44 ($SD = 6.89$) at baseline to 5.38 ($SD = 5.76$) at postintervention. This difference was statistically significant, $t(16) = 2.28, p < .01, ES = 0.95$. Moreover, the difference between those participants who did not attend any family sessions and those who attended at least one family session came close to achieving statistical significance, $t(22) = 1.61, p = .12, ES = 0.66$.

Discussion

This article presents the FCSP, a novel depression prevention program for low-income Latina mothers. As previously noted, the FCSP was designed to build on the emerging depression prevention literature with low-income Latina mothers by incorporating both group and family sessions into the structure of the program. Moreover, considerable attention was given to cultural issues throughout its development. At this early stage of intervention development, we were principally interested in gaining information regarding acceptability of the FCSP to the participants and feasibility of implementation. We were also interested in acquiring some preliminary efficacy data with respect to depressive symptoms. We now discuss these issues in turn.

Participant Recruitment and Retention

Previous researchers have noted that it can be very difficult to recruit and retain low-income Latinos into intervention research (e.g., Miranda et al., 1996). As such, we did not know how acceptable the FCSP would be to our target participants. Our ability to recruit participants into our study was encouraging, however, because approximately 30% of individuals who initially expressed interest in participating in the program ultimately attended at least part of the FCSP. This number of participants compares favorably with recruitment rates reported by other treatment and prevention programs (e.g., Muñoz et al., 1995). In addition, the majority of the women who did not become participants told us to keep their names on the waiting list, because they wanted information regarding any future programs. Thus, our sense is that the FCSP seemed inherently appealing to many of the women we approached in our recruitment efforts.

In addition, we were relatively successful in retaining participants engaged in our study, as over 70% of participants attended

at least four group sessions. Although we did not directly assess participant attitudes regarding the program, our clinical impression was that once participants attended at least one group session, they felt connected to the members of the FCSP team and the other group members. Most of these participants then attempted to come to as many sessions as possible, and usually expressed regret when they were unable to attend a session. Moreover, participants consistently informed us that they had a positive experience, in terms of learning new skills to help them cope with difficult aspects of their lives and meeting other women who share similar life experiences.

We held the first four iterations of the FCSP in a large, urban hospital setting and the last four iterations in a university psychology department lab setting. There is good reason to believe that we would improve initial attendance by holding the program in locations more familiar to potential participants (e.g., local community centers). Some of the participants indicated that they had to overcome some initial anxiety to come to the hospital and believed that community centers would be a more friendly, less intimidating environment. We plan to address this issue by expanding the locations in which we deliver the FCSP, including local community organizations, schools, and churches.

The FCSP family sessions were more difficult to implement than the individual screening sessions and the group meetings. As described earlier, the majority of the reasons for not attending the sessions had to do with schedule conflicts. It is difficult to determine whether scheduling difficulties were indeed the primary reason for low attendance rates or whether family members were simply reluctant to attend the sessions. Attendance at the family sessions improved in the final three cohorts of the FCSP. This improved attendance could be partially due to the fact that the group leader made a stronger effort to explain the importance of the family sessions to the participants in later cohorts. More careful explanation of

the purpose of the family sessions seemed to assuage any concerns that the invited family member would be blamed or attacked by the group leader and may have contributed to the improved attendance. Given the interesting relationship that emerged between the reduction in depressive symptoms and family session attendance, we will be making even more of an effort to encourage participants to attend the family sessions.

One of the modifications to the implementation of the FCSP may be to consider the use of home visits for the family sessions. Although home visits will likely increase compliance, they require additional time and effort on the part of the intervention providers. In the context of a research study, additional energy spent may be worthwhile. However, because one of our long-term goals is to have the FCSP utilized by community practitioners and organizations, home visits may prove to be unwieldy. In the short term, we will likely concentrate on less dramatic modifications, including increasing the flexibility of our availability, offering to contact family members directly to invite them to attend, and spending more time explaining the importance of the family sessions.

Preliminary Change in Depressive Symptoms

Although the pre-post design of this pilot study prevents us from formally evaluating the efficacy of the FCSP, we wanted to obtain a preliminary sense of change in depressive symptoms over the course of the program. This preliminary sense could provide us with an effect size estimate for future research, as well as assure us that the FCSP did not produce any negative effects on the participants. We met these objectives, as we found a significant reduction in depressive symptoms reported by the overall sample. Closer examination of the distribution of depressive symptoms led us to discover some interesting subgroup differences that likely warrant more careful analysis in future research.

First, a clear difference emerged between those participants who were relatively asymptomatic at baseline and those participants who reported mild to moderate levels of symptoms. The asymptomatic participants reported no change in their depressive symptoms over the course of the FCSP, whereas those who had mild to moderate levels of symptoms reported a significant improvement in their symptoms. This pattern in the reduction in depressive symptoms is consistent with that reported by other depression prevention programs (e.g., Cardemil et al., 2002) and might more accurately be considered a treatment rather than a prevention effect. Asymptomatic participants would likely not show any treatment effects due to floor effects of low baseline scores. The true test of any depression prevention program is its ability to prevent the subsequent development of depressive symptoms and episodes. Future iterations of this research will include long-term follow-up assessments.

The second interesting subgroup difference emerged between those participants who attended at least one family session and those who did not attend any family sessions. It is unclear what to make of the significant improvement reported by those participants who attended at least one family session. One possibility is that the family sessions are a critical element in the efficacy of the FCSP. However, given the design of the study, it is equally possible that only those individuals whose symptoms improved were willing or able to attend a family session. It is clear that these results raise some intriguing questions that warrant closer examination.

Future Directions

Prevention programs offer an important opportunity to provide mental health services to individuals from underserved groups. Very few opportunities exist for low-income women (and mothers, in particular) to share their experiences, have their emotional and life experiences validated, and

engage in some problem-solving and skill development. The women who attended our program consistently remarked that they not only learned useful information in the FCSP but also enjoyed sharing their personal life experiences and appreciated the opportunity both to give support to and to receive support from other participants.

Our next step is to more rigorously investigate and quantify the extent to which the participants do indeed benefit from their participation in the FCSP via a randomized controlled trial. We are very encouraged by our preliminary efforts to evaluate the acceptability of the FCSP and the feasibility of implementing it with our target population. We hope that the FCSP can add to the emerging body of prevention research that is beginning to address the mental health needs faced by individuals from underserved populations.

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