

CHAPTER

6

One Size Does Not Fit All: Cultural Considerations in Evidence-Based Practice for Depression

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The purpose of this book, which is to identify and describe in some detail some of the leading evidence-based approaches to treating and preventing depression, is a laudable one and will prove useful to clinicians interested in providing state-of-the-art mental health services. And yet, the term *evidence-based* should be cautiously applied given the limited research evaluating the generalizability of that evidence base to populations other than individuals from European-American middle-class backgrounds (Bernal & Scharrón-del-Río, 2001; La Roche & Christopher, 2008; Mak, Law, Alvidrez, & Pérez-Stable, 2007; U.S. Department of Health and Human Services, 2001).

This limitation in the research base is problematic for several reasons. First, within the United States, the demographics of the population have been rapidly changing; estimates suggest that by the year 2050 the number of U.S. residents who self-identify as European American will be below 50% of the total U.S. population (U.S. Census Bureau, 2008). The situation is even more extreme from a global perspective, as almost 85% of the world population lives outside of the United States and Europe (see Arnett, 2008, for a discussion of the limited scope of psychological research in general). Second, there is some research that suggests that important cultural group differences may exist in the prevalence rate of depression. For example, results from both the original National Comorbidity Survey and the more recently completed National Comorbidity Survey—Replication

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indicated that depression is less prevalent among Latinos and African Americans than among European Americans (Breslau et al., 2006; Kessler, Chiu, Demler, & Walters, 2005; Kessler et al., 1994). Similarly, some research has documented the existence of culturally specific risk factors for depression, including acculturative stress (Mui & Kang, 2006; Torres, 2010) and racial/ethnic discrimination (Seaton, Caldwell, Sellers, & Jackson, 2008).

And third, considerable research has documented significant mental healthcare disparities affecting individuals from low-income and racial and ethnic minority backgrounds (Snowden & Yamada, 2005; U.S. Department of Health and Human Services, 2001). In addition to being less likely than European Americans to receive formal mental health services (Alegria et al., 2002; Wells, Klap, Koike, & Sherbourne, 2001), low-income and racial/ethnic minorities are more likely to prematurely terminate mental health services once connected (e.g., Muñoz, & Gonzalez, 1994).

Thus, the changing demographics of the United States, the emerging research showing cultural differences in the prevalence rate and risk factors for depression, and the well-documented mental health care disparities provide a compelling case that clinical psychology needs to more comprehensively consider diversity in the development and evaluation of evidence-based interventions. And, indeed, the past 15 years has seen an increase in efforts to evaluate the efficacy of interventions that have been adapted for particular cultural populations. In this chapter, we briefly review the evidence supporting the efficacy of the various evidence-based interventions described in this book. We then provide more detail regarding the clinical approaches utilized in those interventions that have been rigorously evaluated with different cultural groups.

How Do We Define Diverse Populations?

Before beginning our review of the literature, we first briefly explain our approach to conceptualizing diversity. Diversity in psychology is a broad term that refers to individuals, personal, and collective identities, and life experiences across a variety of sociocultural constructs, including race, ethnicity, gender, social class, sexual orientation, religion, and disability. Indeed, scholars have written about all of these constructs as they relate to the application of psychotherapy with different populations. In this chapter, we focus on cultural diversity, a concept that touches on the terms *culture*, *race*, and *ethnicity* (Atkinson, Morten, & Sue, 1998; Helms & Cook, 1999). The term *culture* refers to a shared set of social norms, beliefs, and values that particular groups hold and transmit across generations. These norms, beliefs, and values are thought to be learned and cover a wide range of psychologically relevant topics, including gender and familial roles and relationships, styles of interpersonal communication, and philosophical world views (Betancourt & Lopez, 1993). The term *race* has historically tended to refer to physical or biological characteristics that distinguish particular groups of people from other groups (Atkinson, Morten, & Sue,

1998; Betancourt & Lopez, 1993). Although the existence of biological and genetic underpinnings of different racial categories have not been supported by recent biological and anthropological research (A. Smedley & B. Smedley, 2005), the term *race* nevertheless has social significance and meaning to individuals and is commonly used as a proxy for culture and ethnicity. Finally, the term *ethnicity* is generally used to refer to the historical cultural patterns and collective identities shared by groups from specific geographic regions of the world (Betancourt & Lopez, 1993; Helms & Cook, 1999). Some of these patterns include language, history, customs, and rituals.

Although the terms *race*, *ethnicity*, and *culture* have overlap, there are important distinctions among them (Alvidrez, Azocar, & Miranda, 1996; Betancourt & Lopez, 1993). For example, the racial category *white* includes individuals from different ethnic groups (e.g., individuals of British, French, Russian origin), which have different cultural customs. Further, individuals from the same ethnic group may have different cultural traditions depending on where they were raised (e.g., growing up in Mainland China versus growing up in San Francisco).

In this chapter, we use the term *culture* instead of *race* or *ethnicity* when referring to diverse groups of individuals for whom an intervention has been adapted. Using the term *culture* is advantageous because it helps keep salient the fact that culture should be conceptualized as a multidimensional and contextual phenomenon that incorporates a variety of sociopolitical identities, including gender, socioeconomic status, and minority status. The use of the term *culture* can help remind us that it would be problematic to assume homogeneity in cultural worldviews among individuals from the same ethnicity but who vary in their gender, socioeconomic status, and experiences as a minority. This concern is particularly relevant to applying evidence-based practice to diverse cultural groups because the overwhelming majority of cultural adaptations have been developed and evaluated with individuals from racial and ethnic minority backgrounds who also come from low-income backgrounds.

Research Evidence for EBP for Depression With Diverse Cultural Groups

There have been three recent reviews of evidence-based psychosocial interventions for racial and ethnic minorities. Each had a slightly different focus, but in general, the reviews found positive effects when examining the efficacy of evidence-based interventions with individuals from different cultural groups (Griner & Smith, 2006; Huey & Polo, 2008; Miranda et al., 2005). With regard to depression in particular, several studies that included sufficient numbers of individuals from different cultural backgrounds have found support for the efficacy of cognitive-behavioral therapy (CBT) with Latinos and African Americans (Miranda, Azocar, Organista, Dwyer, Arian, 2003; Miranda et al., 2003; Miranda et al., 2006; Organista,

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Muñoz, & González, 1994; Perez Foster, 2007). In addition, several studies that have focused on specific cultural groups have also found support for the efficacy of CBT with Latino adults and adolescents (Arean & Miranda, 1996; Comas-Diaz, 1981, 1986; Rosselló & Bernal, 1999; Rosselló, Bernal, & Rivera-Medina, 2008), African American women (Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002), and elderly Chinese Americans (Dai et al., 1999). There also exists some support for the efficacy of CBT in the prevention of depressive symptoms among Latino adolescents (Cardemil, Reivich, Beevers, Seligman, & James, 2007; Cardemil, Reivich, & Seligman, 2002) and adults (Cardemil, Kim, Pinedo, & Miller, 2005; Le, Zmuda, Perry, & Muñoz, 2010; Muñoz et al., 1995; Muñoz et al., 2007; Vega, Valle, Kolody, & Hough, 1987).

In addition to CBT, there also exists support for the generalizability of interpersonal therapy (IPT) to Latinos and African Americans in the treatment and prevention of depression, the majority of which has been found with perinatal depression. Some of this work with pregnant women has been conducted with Latina women (Spinelli & Endicott, 2003), low-income and African American women (Crockett, Zlotnick, Davis, Payne, & Washington, 2008; Zlotnick, Miller, Pearlstein, Howard, & Sweeney, 2006), and low-income, Latina and African American adolescents (Miller, Gur, Shanok, & Weissman, 2008). In two studies that did not focus on perinatal depression, Rosselló and Bernal (1999) and Rosselló, Bernal, and Rivera-Medina (2008) also found support for the efficacy of IPT with Puerto Rican adolescents.

Taken together, the research evidence generally supports the efficacy of CBT and IPT with Latinos and African Americans. Unfortunately, the research base for the treatment and prevention of depression is significantly more limited for Asian Americans (one study of CBT for Chinese Americans), and nonexistent for individuals from other cultural groups, including American Indians. This lack of research into the generalizability of EBPs is changing, however, as there is increasing attention to the adaptations of EBPs for different cultural groups (e.g., Hwang, Wood, Lin, & Cheung, 2006; Jackson, Shmutzer, Wenzel, & Tyler, 2006; Renfrey, 1992).

Importantly, the majority of studies investigating the efficacy of CBT with different cultural groups have been variants on a series of manuals developed by Ricardo Muñoz and colleagues (Muñoz & Mendelson, 2005). These manuals were themselves based on the Coping with Depression (CWD) course initially developed by Lewinsohn and colleagues (Lewinsohn, Antonuccio, Breckenridge, & Teri, 1984; see Cuijpers, Muñoz, Clarke, & Lewinsohn, 2009, for an extensive review of the CWD course). Similarly, the studies that have focused on IPT have all based their work in the seminal work of Gerald Klerman, Myrna Weissman, and colleagues (Klerman, Weissman, Rounsaville, & Chevron, 1984; Weissman, Markowitz, & Klerman, 2000).

These studies have generally evaluated adapted versions of a standard intervention that the authors believe better address the needs of the target population. Some of the adaptations have been relatively minor, while others have been more comprehensive. It is also important to note that the majority of the cultural adaptations

we reviewed have been developed for low-income populations (e.g., Kohn et al., 2002; Le et al., 2010; Miller et al., 2008; Miranda et al., 2003; Muñoz et al., 2007). As such, these cultural adaptations have necessarily dealt with issues of poverty and social class. In addition, many of the interventions also specifically targeted women and so attended to issues of gender in the development of their programs. In the following sections, we synthesize the different approaches to adaptation of a standard evaluation and provide concrete recommendations for clinicians interested in adapting and implementing an EBP for depression.

How Should EBP Be Adapted for Diverse Populations?

Although the attention to cultural adaptations of EBP has been increasing, there is no consensus regarding how to adapt EBP to clinical work with individuals from different cultural groups (Cardemil, 2008). For example, there are currently no clear guidelines as to when to adapt an intervention, for which specific populations an intervention should be adapted, the extent to which an intervention should be adapted, or how to evaluate the relative contribution of particular adaptations.

Recently, however, several scholars have offered frameworks for integrating cultural issues into evidence-based practice (Barrera & Castro, 2006; Bernal & Sáez-Santiago, 2006; Hall, 2001; Hwang, 2006; Muñoz & Mendelson, 2005; Whaley & Davis, 2007). One early cultural adaptation framework was developed by Bernal and colleagues (1995, 2006), who focused on ecological validity and rooted their approach in a contextualist perspective. Their framework emphasized eight different dimensions to which attention should be given when adapting, or centering, an intervention for a particular cultural group (for an in-depth discussion of these dimensions, see Bernal & Saéz-Santiago, 2006): (1) the language of the intervention; (2) metaphors to be used in the delivery of the intervention; (3) cultural knowledge about client values, customs, and traditions; (4) recognition and consideration of additional contextual influences in the client's life; (5) the client-therapist relationship; (6) conceptualization and communication of the theoretical approach to treatment; (7) agreement on goals of treatment; and (8) methods for reaching goals of treatment. Attention to these eight dimensions would lead to an adapted intervention that is contextually relevant to the targeted population.

Our approach to adapting evidence-based practice to diverse cultural groups complements this approach, as well as others in the literature (Cardemil et al., 2010). In our depression prevention work with low-income, Latina mothers, we conceptualize culture as a multidimensional, contextual phenomenon that includes aspects of gender, socioeconomic status, and the larger systemic barriers our participants encountered in their daily lives. Thus, our cognitive-behavioral intervention incorporates aspects of four broad sociocultural domains: (1) Latino cultural values and life experiences, (2) gender and gender roles, (3) social class and economic stress, and (4) disempowerment in the form of discrimination and difficulty accessing needed

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social services. Concretely, our depression prevention program addresses and incorporates different aspects of Latino culture, issues relevant to women and mothers, the life experiences often found in urban, low-income neighborhoods, and the sense of disenfranchisement felt by many cultural minorities. Moreover, as with the other frameworks and approaches to cultural adaptation, our framework is necessarily flexible and does not assume that every participant has relevant life experiences with each of the four domains. Indeed, we have found significant variability in the extent to which individual participants resonate with different aspects of our attempts to incorporate diversity into our work.

Although the various frameworks in the literature have different perspectives and emphases, they share many commonalities, including the recognition that culture is a complex phenomenon that necessitates addressing diversity in many different ways. In our own work, we attended to three issues of diversity throughout the intervention, including (1) when making decisions regarding various structural aspects of the intervention, (2) in the delivery of the program, and (3) in the programmatic content of each of the sessions. Our review of the CBT and IPT literature suggests that these three areas were also the ones to which other research teams attended in their efforts to develop their cultural adaptations. We now describe each of these three domains in more detail.

Diversity Considerations in the Structure of the Intervention

When clinicians and researchers implement an intervention, they need to consider how the intervention should be organized so as to provide the best therapeutic effect. Some general structural considerations include whether the intervention should be delivered individually or in group format, the number and frequency of sessions, the ordering in which content is presented to participants, and the inclusion of extra-session homework.

Attending to diversity should also take place at the structural level, and many of the interventions we reviewed made explicit structural adaptations to standard 16-session CBT. For example, in one study evaluating CBT with low-income, minority women, Miranda and colleagues (2003) added educational information sessions prior to the intervention in order to help some of the women make informed decisions about whether or not to initiate treatment for depression (Miranda et al., 2003). These sessions were developed in recognition of the variability that exists in many cultures' conceptions of health and illness, and they served as a bridge between the authors' conceptions of depression and treatment and the women's own conceptions. In another study that focused on treating depression among low-income primary care patients with CBT, Miranda and colleagues (2003) added supplementary case management to the CBT (Miranda, Azocar, Organista, Dwyer, & Areane, 2003). The purpose of the case management was to help maintain high levels of engagement with the patients in the study. In addition, the case management also focused on helping the patients cope with ongoing life stressors, many of which were

related to their low-income status. Some of these stressors included problems in housing, employment, recreation, and relationships with family and friends.

Several of the studies we reviewed made the explicit structural decision to deliver the intervention in group format (e.g., Cardemil, Kim, Pinedo, & Miller, 2005; Comas-Diaz, 1981; Kohn et al., 2002; Miranda et al., 2003; Muñoz et al., 1995; Rosselló, Bernal, & Rivera-Medina, 2008). The use of group approaches appeared to emphasize the development of group cohesion around similar culturally relevant life experiences. Interestingly, some of the approaches limited participation to individuals from a single cultural group (Cardemil et al., 2005; Comas-Diaz, 1981; Kohn et al., 2002), while others included individuals from different cultural groups (Cardemil et al., 2002; Muñoz et al., 1995; Organista, Muñoz, & Gonzalez, 1994; Satterfield, 1998). There also existed variability in whether the groups were open to ongoing enrollment by participants. For example, Miranda and colleagues (2003) used an open group format in which new participants joined ongoing groups at the beginning of one of three four-week modules. These authors noted that this approach made the intervention more feasible for ongoing medical referrals. Several other research teams also used this open-group approach (e.g., Organista et al., 1994; Satterfield, 1998). In contrast, a few other research teams explicitly used a closed group approach with the aim of enhancing group cohesion among the participants (e.g., Cardemil et al., 2005; Kohn et al., 2002).

Several research groups who focused on Latinos addressed the importance of family within Latino culture through explicit structural adaptations. For example, in their evaluation of CBT and IPT with Puerto Rican adolescents, Rosselló and Bernal (1999) incorporated a parental interview before and after therapy. This interview allowed the therapist to acknowledge the importance of family obligation and support, the traditional hierarchical nature of Puerto Rican families, and the dependence on parents for instrumental and emotional support. Therapists were allowed to discuss treatment issues with the parents, although confidentiality was guaranteed to the adolescents. Similarly, in our work we explicitly incorporated family sessions into our group prevention work with Latina mothers (Cardemil et al., 2005; Cardemil et al., 2010). The purpose of these family sessions was to welcome participants' family into the treatment process, demystify our intervention, and enlist family members into supporting the participant. We used a broad definition of family, which encouraged participants to invite intimate partners if possible, but allowed participants to invite other important adults if preferred. This flexibility allowed us to take advantage of the extended-family structure that is commonly found in Latino families (Falicov, 1998; Gloria, Ruiz, & Castillo, 2004) as well as helping the significant numbers of single mothers feel welcome in our intervention.

In sum, our review of the literature produced many innovative approaches to adapting the structure of the intervention. These efforts are creative in that they extend the traditional conception of psychotherapy beyond the 50-minute therapy hour so as to best reach different cultural groups. Complementing these structural

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changes is the attention researchers give to the delivery of the intervention, both regarding how therapists interact with the clients and the flexibility in the scheduling of sessions. We now describe these considerations in more detail.

Diversity Considerations in the Delivery of the Intervention

In adapting and applying evidence-based practice to diverse populations, researchers have also focused on the manner in which their intervention has been delivered. A few of the studies we reviewed thought creatively about the location in which the intervention would be delivered and made the decision to hold the intervention in a nonclinical setting. For example, Miller and colleagues (2008), in their prevention and treatment work for postpartum depression among adolescents, held their IPT intervention in school during health classes. Similarly, Cardemil and colleagues (2002, 2007) implemented their CBT depression prevention program during school hours. Holding interventions during school hours has the obvious advantage of making the intervention highly accessible to the participants, normalizing the discussion of mental health topics, and increasing the likelihood that participants feel comfortable.

One innovative approach to this issue was conducted by Vega, Valle, Kolody, and Hough (1987) in their delivery of a cognitive-behavioral depression prevention intervention for Latina women. In their work, rather than use therapists to deliver their intervention in a clinical setting, they used *servidoras*, or indigenous Latina community helpers, and delivered the intervention in community settings. This approach, which has been used in other prevention-oriented health work, is striking in its use of existing community social networks to increase the reach of the intervention.

Researchers have also spent considerable time focusing on therapist behavior when they adapt EBP for diverse populations. Much of this focus has been on having therapists attend to relevant cultural values when interacting with clients. For example, Hwang and colleagues (2006) suggest that clinicians can gain credibility with their Chinese clients by taking into account the importance placed in the Chinese culture on hierarchical relationships, social harmony, and respect for authority figures. Thus, they recommend that therapists present themselves as authority figures with the ability to help their clients solve problems. They also suggest that therapists be proactive in the provision of direction, advice, and teaching skills for symptom relief.

Some of these recommendations are similar to those that have been made when working with individuals from other cultural groups. For example, some researchers have suggested that in American Indian communities, traditional healing practices encourage clients to take on a passive role in deference to the expert healer (Dinges, Trimble, Manson, & Pasquale, 1981). This passive role would encourage a more active, directive approach by the clinician, although as Renfrey (1992) warns, an overly directive style can run the risk of positioning the clinician as a controlling agent of the dominant culture.

With regard to working with Latinos, various scholars have written about the use of certain important Latino values, including *personalismo*, *respeto*, and *familismo* (e.g., Muñoz & Mendelson, 2005; Rosselló & Bernal, 1999). In our own group work with low-income Latinas, we also used these three values in order to gain traction for the delivery of our prevention program. Throughout the intervention, leaders strove to maintain a friendly and relaxed environment so as to sustain an air of *personalismo*, which refers to the emphasis on close interpersonal relationships. This was accomplished in various different ways, namely through self-disclosure, diffusion of the expert role to include the participants as a source of expertise, and through the provision of food during the sessions. One good example of how self-disclosure can lead to increased rapport with group members can be seen in this exchange following the self-introduction of one of the group leaders¹:

Group Leader (GL): Good morning, everyone. My name is Suzette, and I am Venezuelan and I have lived in this country for about 13 years. In that respect, English is my primary language now because I have been using it since I was 12.

Alma (A): I'm sorry; I believed that you were from here.

GL: No, don't worry. Everyone thinks that. I am Venezuelan, I was born there and was raised there up until I was 11 or 12. My family then moved to the United States. So, yes, sometimes I forget my Spanish because that is what happens when you do not use the language all that often. So, at times I'm going to make a mistake, so please have patience with me and help me, please

A: My children tell me the same thing, because my children came to this country when they were young.

GL: Uh hum.

A: My littlest tells me, he says "Momma, I am forgetting Spanish" and I tell him not to forget because to speak two languages, one counts for two.

By expressing some vulnerability regarding her Spanish-speaking ability, the group leader reduced some of the distance that commonly exists between therapists and clients. Moreover, the exchange led one of the participants to describe a commonly experienced culturally relevant stressor for Latinos: namely, the desire to have one's children speak Spanish and be connected to one's culture of origin.

This effort to maintain *personalismo* is integrated throughout different facets of our intervention, but it is also tempered by the Latino value of *respeto*—the emphasis on showing respect and differential behavior to others. This is done in several ways, but most obviously through the use of formal language (e.g., using the formal *usted*

¹The names of group members and group leaders have been changed to preserve their confidentiality. In addition, all transcripts have been translated from their original Spanish.

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and not the informal *tú* when addressing participants and family members in the second person).

It is important to remember that attention to therapist behavior should not be limited to cultural values. Rosselló and Bernal (2005) describe their attention to issues of poverty among their population. They note that the therapists in their study were sensitized to the economic, racial, and cultural diversity in their clients as well as the different ways of living that may result from this diversity. They also encouraged therapists to discuss socioeconomic and racial differences with their clients should the need arise. Similarly, we are cognizant of the ways that socioeconomic stress places significant competing demands on many of our participants' schedules (e.g., multiple jobs, various appointments with different social service agencies, transportation difficulties). Thus, we attempt to schedule appointments flexibly, including in the early morning and evening hours as well as on weekends. We also offer bus passes or taxi vouchers to all participants and provide on-site childcare for those participants who need it.

Diversity Considerations in Program Content

In addition to creatively modifying the structure and the delivery of the intervention, efforts to evaluate the generalizability of interventions with different cultural groups invariably also adapt the content of the program. In our review of the literature, we found two main approaches to incorporating diversity issues into program content. Some research teams adapt the intervention manuals to explicitly include modules that address culturally relevant themes. An excellent example of this approach can be seen in the work of Laura Kohn and colleagues (2002), who adapted a cognitive behavioral group treatment for use with depressed low-income African American women. In addition to the standard cognitive-behavioral modules on cognitions, activities, and relationships, these authors added four culturally specific sessions: (1) creating healthy relationships, (2) spirituality, (3) African American family issues, and (4) African American female identity. Of note is that these additions were grounded in the theoretical and clinical research as well as interviews with therapists who had worked with African American women.

In addition to this approach, many of the adapted interventions modified the material in the manuals that highlighted particular emotion regulation skills and problem-solving approaches. This standard material often takes the form of stories, didactic exercises like worksheets, and interactive role-play exercises that make the thematic and didactic material more accessible to the clients. This material is usually located in the therapist and participant manuals, with the intention of being used as both in-session work and homework. The cultural adaptations of this material typically consists of highlighting and working through culturally relevant life stressors, including immigration and immigration-related stress, experiences with prejudice and discrimination, and interfamilial stress related to acculturation (e.g., Cardemil et al., 2005, 2010; Muñoz & Mendelson, 2005). Several interventions also

emphasized including material that highlighted stressors associated with urban poverty, including exposure to violence, difficulty accessing services, and financial stress (Cardemil et al., 2002, 2007; Miller et al., 2008). Other authors found ways to incorporate spirituality and religion into the intervention (Kohn et al., 2002; Muñoz & Mendelson, 2005). Le, Zmuda, Perry, and Muñoz (2010) describe their use of hand-drawn stories that resembled *telenovelas*, or soap operas, to describe how one's choices can influence one's mood and well-being.

In our depression-prevention program for Latina mothers, for example, we utilize commonly experienced difficult decisions to build rapport and cohesion among the participants. We begin this process early in our first group session by asking our participants to generate a list of difficult experiences related to being a Latina mother. One commonly cited difficulty that participants have mentioned is not being able to communicate with their children's school personnel because of their inability to speak English well. In one group we led, the participants were somewhat quiet, providing relatively short answers to questions from the group leader. However, when one of the participants mentioned not being able to communicate with her child's school teacher, other participants became more engaged in the discussion, sharing their experiences and relating to one another. This conversation unfolded as follows:

Group Leader (GL): What are some other difficulties related to being a Latina mother?

Julia (J): Not knowing English, so I can't communicate with my child's school.

GL: Has that happened to anybody else?

Erica (E): Yes. It is very difficult when all you know is Spanish and in school the teachers speak English.

Isabel (I): Before, I had this problem. I could not communicate because I only knew a little bit of English. Now, I know more English, so it is not as difficult.

J: A lot of times, [my children] serve as interpreters. They can dominate the language better.

E: That is true; my son is always my interpreter.

GL: So your children help you then?


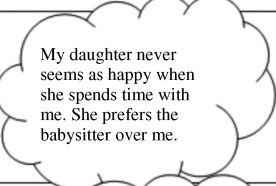


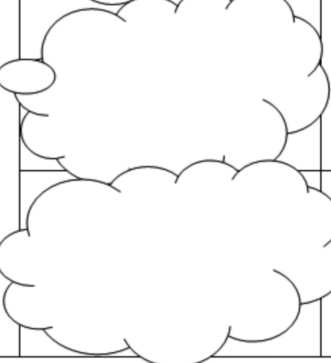


I: Yes.

J: Yes. He helps me with my writing and I always ask him for help when I need it.

E: I also ask my child for help with English.

As can be seen from this transcript, there was considerable group discussion around this topic. Each of the participants found a way to relate to this issue, including one who no longer experienced it due to the improvement of her English-speaking ability. Further, this discussion led to the spontaneous generation of another commonality—the use of children as interpreters.

Figure 6.1 Worksheet Used in Family Coping Skills Program

Event	Belief/Thought →	Feeling Consequence
		 8—Very Sad
		 6—Happy
		 3—Anxious

Another example that invariably generates discussion involves having the participants imagine returning from work to find their children playing happily with a babysitter. The babysitter then states that the day went very well, that the children behaved wonderfully, and that there were no problems at all. Invariably, this scenario provokes discussion around motherhood and whether children should be left with nonfamilial caretakers. Many of the participants in our program have told us that they have a strong desire to never leave their children in the care of a nonfamily member (consistent with the cultural value of *familismo*), but that economic circumstances have required them to act against this desire. In addition, this example usually provokes a range of emotional reactions that includes pride, regret, disappointment, and surprise. We then transition to cartoon-like worksheets that highlight the relationships among situations, thoughts, and feelings (see Figure 6.1). Thus, because this scenario is meaningful to our participants both through their cultural values and life experiences; it brings to life the cognitive principles of interconnections among situations, thoughts, and feelings.

In addition to the worksheets, we also use interactive role-play exercises that focus on a character's negative thinking around a particular situation. The participants will read aloud the example, identify the negative thinking, and generate several alternative ways of thinking about the situation. One of our role-play situations describes a mother (Susana) whose son resists attending church with the rest of the family, stating that he would prefer to spend Sunday mornings playing with his friends. Some of the mother's negative thoughts include thinking that her

son does not care about her family and that she is losing him to the larger U.S. culture. This example has resonated with many of the participants in our program, most likely because it taps into two relevant aspects of Latino culture: family and religion. This can be seen quite well in the following transcript of a different group session with three other participants:

Group Leader (GL): What are the negative thoughts that Susana is having?

Maria (M): Thinking she is a horrible mother.

Juana (J): The thoughts about being a terrible mother.

GL: What more positive things could Susana have told herself so she can feel a little bit better and not feel so bad, like she feels now?

M: She could have talked to her son. Her son could please her and go to church and then she can please him so he can go with his friends.

GL: Then maybe a compromise right?

J: Exactly

GL: Come to church with me today and tomorrow you can go with your friends.

Julia: Yeah, let's negotiate. Let's go to church in the morning and after you can go with your friends.

GL: Has something similar ever happened to any of you?

Julia: Yes

GL: What did you tell yourself when you had to face this situation?

Julia: In my situation, my son was the Catholic one and was the one that went to church. He wanted to take me to church and invited me; everything changed though. He entered teenage years and his friends would make fun of him saying he looked like a girl at church. He changed his way of thinking and didn't want to go to church because of his friends. Then I started to go and invited him and he said no. I felt uncomfortable because my son learned some good principles and wanted to project them onto me, but when I wanted to project them to him, he didn't want to anymore. I lost that opportunity to be with my son when he needed me.

M: My situation was with my husband. He wanted to take me to church but I would always tell him give me time. I would join him even when his religion was different, until he stopped going.

GL: Now Susana is telling herself very negative things. "My son does not care about his family." This is an exaggerated thought, right? What could have Susana told herself?

J: Give her son some time and let him go with his friends, but continue to invite him to go.

M: Do not obligate him to go but invite him.

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Julia: Don't push him but remain positive. It might not even be about his family or the values.

GL: She is saying "I am losing him to his friends and to the American culture." This is something that we talked about last week. A change of culture and a change of values are going to be different. What do you think about this? What if your kids don't want to go to church and are losing their cultural values? What could you tell yourself?

Julia: My son is learning a new culture and value and I will talk to him later so he won't lose ours.

M: I will give him time.

J: Or we invite the friends and we can all go to church, and then we can all go to the movies after.

As can be seen, this role-play led to a good discussion that involved all of the participants. Each of the participants had had personal experiences similar to that described in the role-play, which allowed them to share their own situations, how they thought about them, and how they attempted to resolve their problems.

Other culturally relevant role-plays we use include one in which a mother misses a deadline to register for a free ESL class because she could not find child care, a mother who cannot afford to host a *quinceañera* (sweet 15th birthday) celebration for her daughter, and a mother who worries about communicating in English with her children's teachers. Although not all of the role-plays explicitly address culturally salient issues, they all are designed to allow for the introduction and practice of cognitive-behavioral skills in practice situations that are especially relevant to the participants.

Use of Culturally Relevant Metaphors and Sayings These examples are a few of the exercises we use to infuse our depression prevention program with culturally relevant content. However, as noted earlier, including culturally relevant content is important, but insufficient (Bernal & Sáez-Santiago, 2006; Hwang, 2006). Muñoz and Mendelson (2005) describe how in addition to explicit discussion of relevant content like spirituality and religion, acculturation, and experiences with racism, discrimination, and prejudice, cultural adaptations should include the use of culturally relevant metaphors and stories as a means to convey key therapeutic principles. In their programs, they used culturally relevant images, metaphors, and stories that were used to illustrate key concepts with their Latino clients. For example, the saying, *La gota de agua labra la piedra* (Drops of water can carve a rock) was used to illustrate how pervasive negative thinking can gradually affect one's view of life and produce and maintain depression (Muñoz & Mendelson, 2005). Rosselló and Bernal (2005) note their use of the Puerto Rican expression *Todo se ve a través del cristal con que se mira* (Everything is seen through the crystal with which one looks) to highlight how cognitions can affect one's understanding of situations.

Hwang and colleagues also describe their use of culturally relevant terms and concepts to facilitate the introduction of cognitive-behavioral concepts. In particular, they describe their use of Chinese metaphors and stories embedded in four-word sayings known as *Chengyu*, which are ethical and moral guidelines for individual behavior (Hwang et al., 2006). These principles were used as clinician tools to help clients reframe their maladaptive thinking and engage in healthier activities (Hwang et al., 2006). One example that Hwang cites is a well-known *Chengyu* story about a master artist who practiced using two brushes simultaneously in one hand to create unsurpassed paintings (*shuang guan ji xia*; translated as “two brushes painting together”; Hong, 1987). Hwang and colleagues used this story to highlight for clients the use of employing multiple CBT principles simultaneously (e.g., challenging maladaptive cognitions, developing replacement coping thoughts, and engaging in behavioral strategies to improve mood).

These examples are a few of the many that others in the literature have noted (e.g., Zuñiga, 1991, 1992). And although the use of metaphors, myths, and stories should be undertaken with caution given the within-culture variation that exists in familiarity with individual stories, when judiciously applied, they can nicely integrate some of the active ingredients of the intervention with worldviews and sayings of the particular culture.

Recommendations for Applying EBP With Diverse Populations

The literature we have reviewed highlights the progress that has been made in evaluating the generalizability of EBP for depression, increasing our confidence in applying some EBP with some cultural groups. However, the fact remains that the evidence base is more limited with other EBP, and in general, the evidence base is limited with individuals from some cultural groups. Given the current state of the field, how should clinicians proceed in the delivery of EBP for depression? Our review of the literature yielded a few concrete recommendations that we discuss in turn. Given the limited space in this chapter, we also provide a separate section for additional readings for interested clinicians.

Learn More About the Cultural Groups With Whom You Desire to Work

Despite the obvious nature of this recommendation, its importance warrants explicit mention. Before attempting to adapt an intervention for a particular population, clinicians should familiarize themselves with the extant sociological and psychological literature on that population. The familiarity that the different research teams had with their target populations allowed them to hone their adaptations in ways that were most appropriate and relevant to those particular populations. For example,

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most of the research teams working with Latino populations touched on topics of immigration and acculturation. These issues would likely be salient when working with other immigrant populations, but would be less so when working with cultural minority groups that were not immigrants (i.e., African Americans, American Indians).

In addition, important subgroup differences may exist that affect the clinical presentation of local populations. For example, while the Latino population in California and the Southwest U.S. is composed primarily of individuals from Mexico, Latinos in the Northeast U.S. are predominantly individuals from Puerto Rico, the Dominican Republic, and Central America. Le et al. (2010) provide an excellent description of how they modified some of the Spanish in their intervention to make it more relevant to the Central American women in their study. Similarly, clinicians working with American Indian populations are surely aware of the fact that there exist more than 500 federally recognized American Indian tribes and so there exists considerable variation in cultural practices and beliefs (Renfrey, 1992). In addition to differences in cultural beliefs and practices, there are often differences in language and expressions across these groups.

So we recommend that clinicians work to familiarize themselves with the relevant cultural groups in their area. In addition to reviewing the relevant literature, we recommend that clinicians seek out opportunities to gain experiential familiarity with their local populations. This experiential familiarity can be obtained in a variety of ways, including creative outreach efforts to established community leaders like health-care providers, religious leaders, and school board members (Domenech-Rodriguez & Wieling, 2004; Le et al., 2010). These outreach efforts can even lead to the creation of a community advisory board that can provide regular input on the development and implementation of a novel treatment program. Focus groups with current mental health consumers could also provide valuable information about local stressors and issues (e.g., Nicolas, Arntz, Hirsch, & Schmiedigen, 2009). Through the process of learning about the local community, decisions can be made regarding precisely for whom and how the interventions should be adapted.

Remember to Balance Group and Individual Characteristics

Our next recommendation provides a counterpoint to the first recommendation by highlighting the importance of acknowledging the tremendous heterogeneity that exists within the different cultural groups in adherence to cultural practices, values, and worldviews. Some of this variability may result from individual differences in acculturation, ethnic identity, and life experiences (Chun, Organista, & Marín, 2003; Phinney, 1996). Further, the multidimensionality of culture leads individuals to have multiple sociocultural identities that become more or less salient depending on the context (e.g., gender, sexual orientation, age, religious affiliation). Thus, it is problematic to assume that every individual from a particular cultural group will share characteristics that have been typically ascribed to that cultural group. And yet, to

ignore completely the existence of individual connections to a larger cultural group misses a large part of the human identity and experience.

Therefore, incorporating diversity considerations into clinical practice requires balancing an understanding of the values, attitudes, and life experiences at the cultural group level with the values, attitudes, and life experiences that are unique to every individual and which may be related to those of the larger cultural group. Too much attention to the larger cultural group can lead to stereotyping, and too much attention to the individual can lead to misunderstandings related to cultural differences. Achieving this balance between the group and individual-level characteristics is not easy, but it is the same therapeutic skill that is applied regularly by clinicians for noncultural reasons. For example, clinicians who work with recently divorced parents would likely balance their understanding of the stressors commonly associated with divorce and coparenting with recognition that individuals may or may not experience those particular stressors.

Scholars in the area of multicultural counseling have written extensively on this issue and generally emphasize the importance of keeping cultural considerations as hypotheses or questions, rather than as fixed assumptions (e.g., Cardemil & Battle, 2003; Hays, 2009; D. W. Sue & D. Sue, 2008; S. Sue, 1998). Further, building on the first recommendation, increased personal familiarity with different cultural groups makes it easier to maintain this balance.

Think Broadly About How to Integrate Diversity Considerations

Much of the literature on working with diverse populations focuses on the therapist-client relationship (e.g., La Roche & Maxie, 2003; S. Sue, 1998). However, the literature we reviewed highlights the importance of integrating diversity considerations much more broadly. Studies we reviewed consistently attended to diversity in the structure of the interventions, in the content or material of the interventions, and in the manner in which the intervention was delivered. This comprehensive attention to diversity likely contributed to the success of the adapted interventions, both in terms of efficacy but also in terms of retention and engagement of participants.

Thus, clinicians interested in adapting evidence-based practice to diverse populations would do well to think beyond the therapist-client relationship. Although certain logistical and financial factors will likely influence decisions about what particular structural adaptations to make, there is still considerable room for creativity in the implementation of interventions. Some areas where structural considerations could be made to explicitly consider diversity include the modality of treatment (e.g., group versus individual, open versus closed), the frequency and regularity of sessions, and the length of individual sessions. Building on the community work discussed earlier, structural considerations could also include innovative approaches to outreach, psychoeducation, and prevention that are not commonly implemented in formal mental health settings. In general, we encourage

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clinicians to think flexibly and outside the box regarding how to best implement their EBP and to attend to the feedback they receive from their clients regarding these changes.

Diversify Research, Clinical, and Support Staff

One important fact about the efforts to investigate the generalizability of EBPs to different cultural groups is that the research and clinical have generally themselves been diverse in their make-up. Muñoz and Mendelson (2005) highlight how having individuals from the targeted cultural groups help with intervention development changes the process from one of literal translation into one of true culturally appropriate adaptation. Further, prioritizing diversity in the hiring of clinical and support staff can also play an important role in helping with implementation of EBPs to diverse groups. As we noted in our earlier recommendation, thinking about cultural issues goes well beyond focusing on the therapist-client relationship and so it is important to comprehensively hire diverse staff at all levels of mental health care.

In our own work, we also have a culturally diverse team of researchers and intervention leaders. But just as important, each individual on our team also has considerable experience working with our population of low-income, Latina women. Even though not all of the team members are Latino, each has considerable familiarity and experiencing working with Latinos and low-income clients. Moreover, all team members are fluent in both Spanish and English.

Concluding Thoughts

Despite the tremendous advances that have been made in the past 25 years in the evaluation of psychosocial interventions for depression, there remain significant limitations in our ability to make claims about the generalizability of these interventions to individuals from different cultural groups. Promising advances have been made documenting the efficacy of CBT and IPT, primarily with Latinos and African Americans, and researchers are beginning to turn their attention to other cultural groups. The extant literature on the cultural adaptation process has led to the formation of a knowledge base for how to proceed with adapting interventions for particular cultural groups, and we are optimistic that this base will allow for increased attention and growth in this area.

In many ways, clinicians are leading the way in the enhancement of this knowledge base, as the increasing diversity of clients precludes waiting for the evidence base to be finalized. And so by carefully reviewing the cultural adaptation literature, following some of the recommendations we provide in this chapter, and maintaining a humble and optimistic approach to the therapy process, clinicians can prepare themselves well for the challenges and rewards of conducting clinical work in the 21st century.

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