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Enhancing Group Cognitive Behavioral Therapy for Hispanic/Latino Clients with Depression : Recommendations for Culturally Sensitive Practice

Elizabeth Suarez Kuneman

Philadelphia College of Osteopathic Medicine, elykuneman@comcast.net

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Philadelphia College of Osteopathic Medicine

Department of Psychology

ENHANCING GROUP COGNITIVE BEHAVIORAL THERAPY FOR
HISPANIC/LATINO CLIENTS WITH DEPRESSION: RECOMMENDATIONS
FOR CULTURALLY SENSITIVE PRACTICE

By Elizabeth Suarez Kuneman

Submitted in Partial Fulfillment of the Requirements of the Degree of

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DEPARTMENT OF PSYCHOLOGY

Dissertation Approval

This is to certify that the thesis presented to us by Elizabeth S. Kuneman completed the oral defense of the dissertation on the 27th day of May, 2010, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

Bruce Zahn, Ed.D., ABPP, Chairperson

Petra Kottsieper, Ph.D.

Dr. Tamara Walker-Gladney

Robert A. DiTomasso, Ph.D., ABPP, Chair, Department of Psychology

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Abstract

Using a qualitative approach, this study explored the process of developing treatment suggestions for adding cultural sensitivity to an empirically supported, group cognitive-behavioral therapy (CBT) treatment manual for Hispanic/Latino clients with depression. Suggestions were formulated through the implementation of one vignette centered on a male character, addressing Hispanic/Latino cultural values as described in the literature. This researcher sought bilingual mental health providers (English-Spanish/Spanish-English) who worked with Hispanic/Latino clients; four from a group of ten who responded, reviewed the researcher's suggestions and answered a seven item semi-structured questionnaire, which was developed to elicit their comments. Analysis of the data revealed themes that endorsed the importance of addressing traditional cultural values when serving these clients, including *familismo*, *dichos*, *fe*, social and family network, gender role expectations, and stigma associated with mental health services. Implications for clinical practice, limitations of the study, and recommendations for future research were discussed.

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CHAPTER ONE

Introduction

Statement of the Problem

Throughout its history the United States of America (USA), as a nation built on immigrants, has experienced challenges and difficulties in pursuing the understanding and integration of racial and ethnic diversity into its societal structure. At the present time, these challenges appear to be greater than ever, especially as the face of our national identity becomes more diverse. Psychologists cannot avoid experiencing these challenges. They are continuously faced with the demand of providing mental health care to a wide range of clients of diverse races, ethnicities, nationalities, and religions. Fortunately, in recent years, there has been a remarkable emphasis on psychologists' awareness of multicultural issues and the impact of these issues in treatment (Lo & Fung, 2003; Sue & Sue, 2003). Psychologists have begun to understand that their ability to provide effective treatment interventions to their clients is limited as long as their methods rely solely on constructions and ideologies associated with mainstream American culture. They realize that they can more accurately treat the mental health concerns of their multicultural clients by paying attention to the differences across cultures. Furthermore, these professionals have come to recognize the benefits of culturally sensitive treatment interventions and have discovered that targeted interventions to a specific cultural group are more effective than those interventions traditionally provided to mixed groups, which consisting of clients from a variety of cultural backgrounds (Sue, 2003). Thus psychologists are making significant efforts to

provide interventions that are culturally attuned by acquiring cultural literacy and competence to respect and understand the unique heritage and beliefs of their clients.

Although psychologists appear to agree on the benefit and relevance of culturally sensitive treatment interventions to meet their clients' needs, there is limited research on the implementation of adaptations of empirically supported treatments that take culturally sensitive practices into account. Subsequently, studies that promote the investigation of cultural adaptation of treatment protocols may provide significant contributions to the field of psychology. A valuable contribution would be that of a study seeking to deliver culturally sensitive, and empirically supported treatment to vulnerable populations suffering from a mental disorder such as depression.

Depression can be a pervasive mental disorder that affects individuals of all racial, ethnic, and socioeconomic backgrounds. It causes significant human suffering and loss of productivity (Greenberg, Stiglin, Finkelstein, & Berndt, 1993). Depression affects the most vulnerable populations such as low-income and of ethnic minority groups, including Hispanic/Latinos. Hispanic/Latinos are at great risk for depression (Hovey, 2000), which can adversely affect their interpersonal relationships and most significantly, their family systems, which they consider the focus of their lives. The literature suggests that Hispanic/Latinos typically underutilize mental health services and experience disparities in accessing care for their mental health needs (U. S. Department of Health & Human Services [USDHHS], 2001; American Psychiatric Association [APA], 2007). They seek treatment only when their problems become severe, and often drop out of therapy prematurely (Alegria et al., 2002; Schraufhagel, Wagner, & Byrne, 2006; USDHHS, 1999, 2001). Furthermore, Hispanic/Latino clients are susceptible to

psychotherapists' limitations in providing culturally sensitive and responsive therapy to them (Altarriba, 2003; Fraga, Atkinson, & Wampold, 2004). This is not to suggest that psychotherapists discriminate against Hispanic/Latino clients, but rather, to emphasize the fact that they may not always be familiar with the cultural worldviews, life styles, and histories of Hispanic/Latino groups.

There are currently few culturally sensitive, empirically supported mental health treatments that have been validated on Hispanics/Latinos; this limits the opportunity of these individuals to benefit from evidenced-based treatment. Cognitive-Behavioral Therapy (CBT) has traditionally been presented in the context of empirical demonstrations as an effective method for the treatment of many mental disorders such as depression (National Institute of Mental Health [NIMH], 2003). Some scholars (Guarnaccia, Martinez, & Acosta, 2002) theorized that CBT methods can effectively treat Hispanics/Latinos, if translated into the Spanish language and adapted to meet their cultural beliefs. CBT methods focus on working with various forms of clients' cognitions and their behavioral performances, and therefore, cross-cultural differences in the clients' affect, their behavior, and their well being have important implications for the outcome of CBT interventions. CBT methods provide a great opportunity to adapt and deliver treatment services that are empathetic to Hispanics/Latinos' beliefs and values.

Purpose of the Study

The qualitative study described herein will explore the degree to which CBT methods can be effectively adapted to be more culturally sensitive when treating adult Hispanic/Latino clients. Specifically, the study is aimed at adapting an empirically supported treatment manual for depressed clients in a manner that it is compatible with

Hispanics/Latinos' cultural values and beliefs, as described in the literature. In that pursuit, the study will examine the Group CBT manual for depression "*Guia para Miembros del Grupo*" (Guidebook for Group Members) authored by Jeanne Miranda, Ph.D. and colleagues (2006); this will provide recommendations for ways in which the manual might be enhanced for use with this ethnic minority group, and will explore the suitability of such recommendations, by seeking comments and feedback from bilingual mental health providers who work with Hispanic/Latino clients in different regions of the U.S. Methods of inquiry will include qualitative reflection on the recommendations provided by the researcher and the data elicited by the participants' reviews and comments.

Relevance of the Study to Clinical Psychology

This study is motivated by an interest in the crossroads between culture and psychotherapy and the desire to increase awareness on the already acknowledged need for cultural sensitivity in the field of psychology. The study attempts to contribute to the improvement, accessibility, and efficacy of cognitive therapy for adult Hispanic/Latino clients diagnosed with depression. The study advocates the theory that to maximize treatment retention and outcomes when providing mental health services to Hispanic/Latino clients diagnosed with depression, traditional CBT may be modified to improve the match of these clients' cultural contexts.

CHAPTER TWO

Literature Review

Hispanics - Latinos

Demographics

The Hispanic/Latino community in the United States (U.S.) comprises a diverse group of people who come from different Spanish-speaking countries. They are from different nationalities, races, socioeconomic, and educational levels. Some have lived in the country for many generations, whereas others are new immigrants who have come seeking to improve their standards of living (e.g., overcoming poverty), professional opportunities or to escape from political oppression (American Psychiatric Association [APA], 2007).

Hispanics/Latinos are the largest ethnic minority group in the United States. They accounted for 12.5% of the U.S. population in the 2000 Census (U.S. Department of Health and Human Services [USDHHS], 2001). This minority group rose from 9.1% (22 million) in 1990 to 13.4% (39 million) in 2003 (U.S. Census Bureau, 2003), and it has been predicted that they will compose approximately 25% of the U.S. population by 2050 (USDHHS, 2001). They have remained the largest minority group, with 44.3 million (14.8%) in July 2006 (U.S. Census Bureau, 2007). African-Americans were the second-largest minority group, totaling 40.2 million in 2006. They were followed by Asian (14.9 million), American Indian and Alaska Native (4.5 million), and Native Hawaiian and other Pacific Islander (1 million). The population of non-Hispanic Whites who indicated no other race totaled 198.7 million in 2006. These data indicate that the nation's minority population reached 100.7 million in 2006, suggesting that there are more minorities in

this country today than there were people in the entire population of the U.S. in 1910 (U.S. Census Bureau, 2007). Although Hispanics/Latinos are the fastest-growing minority group, they face remarkable economic and social barriers in this country. In 1999, only 8% of non-Latino Whites were estimated to be living in poverty, whereas poverty rates were estimated at 14% for Cuban Americans, 27% for Mexican Americans, and 31% for Puerto Ricans. Furthermore, only 56% have graduated from high school, compared with 83% of the total U.S. population (USDHHS, 2001). The heterogeneity and the numerous cultural dimensions associated with Hispanics/Latinos' unique life experiences convey complexity to the understanding of their lives in the U.S. (Santiago-Rivera, 2003).

The Distinction between Hispanics and Latinos

Researchers do not seem to agree on whether the term *Hispanics* or the term *Latinos* better personifies this ethnic minority group. Although often used interchangeably in the literature, the terms are not synonymous and in certain contexts the choice between them can be significant. Furthermore, choosing one term over the other can be perceived as taking a political, social, and even a generational stand. Thus, psychologists need to know and understand the meaning behind both terms and ask their clients how they view themselves and how they prefer to be called.

The word Hispanic (*Hispano*) derives from the Latin word Hispania, which refers to the people and culture of the Iberian Peninsula, Spain (*Espana*). The term Hispanics refers to people whose culture and heritage have ties to Spain (American Heritage Dictionary of the English Language, 2000; Novas, 2008); this also applies in the case of second and third generation Hispanic-Americans, who may or may not speak Spanish.

The term Hispanic has been used in referring to Spain and its subsequently conquered territories which covers most of Latino America, including Cuba, Puerto Rico, Republica Dominicana, Mexico, Nicaragua, Costa Rica, Guatemala, El Salvador, Honduras, Panama, Venezuela, Colombia, Ecuador, Peru, Bolivia, Chile, Argentina, Uruguay, and Paraguay. Novas (2008) referred to people from these countries as Spanish-speaking Latin Americans, “relatives” of Hispanics. The term Hispanic gained acceptance in the United States (U.S.) after its use by the government in forms and in census gathering to identify people with Spanish heritage. Hispanic is not a race but an ethnic distinction, and Hispanics come from all races and have various physical traits. Latin America is a geographic location and individuals from Latin America are all Latin, but not all are Hispanics. For instance, Brazilians, who speak Portuguese, are Latin but not Hispanic (El Boricua, n. d.; Novas, 2008). Although all U.S. citizens and residents of the United States who originated from Spanish-speaking, Latin American countries, or whose ancestors did, are known as Hispanics, many scholars limit the definition to those of Spanish-speaking, Latin American origins.

It is interesting that European Americans in the U.S. are categorized by their countries of origin in the mainstream culture (e.g., Irish Americans, Italian Americans, Russian Americans, etc.); however, individuals with roots in the eighteen sovereign nations and the U.S. commonwealth of Puerto Rico, listed previously, are classified by their mother tongue, Spanish, despite their own distinct cultures, histories, indigenous language(s), culinary traditions, and individual philosophies. People in Spanish-speaking Latin American countries do not call one another Hispanic because national identity takes

precedent. Therefore, the term “Hispanic” does not give regard to Hispanic individuals’ countries of origin (Novas, 2008).

The polemic with regard to the use of “Hispanic” vs. “Latino” prevails even within the Hispanic/Latino community in the U.S. Some feel quite strongly about rejecting the term “Hispanic”, considering it a U.S. government census term that was imposed upon them, and, it has further implications because it connotes the Spanish colonization of Latin America. They prefer the term “Latino” or “Latina” because “Hispanic” implies colonization. Others are not bothered by the Hispanic-Latino polemic and do not find the term “Hispanic” offensive (Novas, 2008). In spite the controversy and despite how Hispanics/Latinos view themselves, the community as a whole presents a united front, with solidarity that prevail across subgroups. Nonetheless, psychologists should understand the impact they may have when calling their clients either Hispanics or Latinos.

The literature emphasizes the complexity, confusion, and controversy associated with the usage both of the term Hispanic and of the term Latino, which may help explain the reason why researchers cannot agree on the distinctiveness of such terms to identify individuals from this ethnic minority group. The American Heritage Dictionary of the English Language (2000) states:

Hispanic, from the Latin word for “Spain,” has the broader reference, potentially encompassing all Spanish-speaking peoples in both hemispheres and emphasizing the common denominator of language among communities that sometimes have little else in common. *Latino*—which in Spanish means “Latin” but which as an English word is probably a shortening of the Spanish word *latinoamericano*—refers more exclusively to persons or communities of Latin American origin. Of the two, only *Hispanic* can be used in referring to Spain and its history and culture; a native of Spain residing in the United States is a *Hispanic*, not a *Latino*, and one cannot substitute *Latino* in

the phrase *the Hispanic influence on native Mexican cultures* without garbling the meaning. In practice, however, this distinction is of little significance when referring to residents of the United States, most of whom are of Latin American origin and can theoretically be called by either word. A more important distinction concerns the sociopolitical rift that has opened between *Latino* and *Hispanic* in American usage. For a certain segment of the Spanish-speaking population, *Latino* is a term of ethnic pride and *Hispanic* a label that borders on the offensive. According to this view, *Hispanic* lacks the authenticity and cultural resonance of *Latino*, with its Spanish sound and its ability to show the feminine form *Latina* when used of women. Furthermore, *Hispanic*—the term used by the U.S. Census Bureau and other government agencies—is said to bear the stamp of an Anglo establishment far removed from the concerns of the Spanish-speaking community. While these views are strongly held by some, they are by no means universal, and the division in usage seems as related to geography as it is to politics, with *Latino* widely preferred in California and *Hispanic* the more usual term in Florida and Texas. Even in these regions, however, usage is often mixed, and it is not uncommon to find both terms used by the same writer or speaker.

Although the question remains about whether Hispanics/Latinos are Spanish speakers or are people of Spanish heritage, what matters is that psychologists be prepared to recognize and respect the cultural legacy and cultural differences of their clients in this ethnic minority group. Therefore, it is relevant that psychologists assess and acknowledge their Hispanic/Latino clients' self cultural identifications from the start.

At present, the term *Latino* is commonly used by Latinos and non-Latinos when referring to both immigrant and U.S. born Americans of Latino ancestry (Organista, 2006). Organista and Munoz (1996) offered the following description about Latinos:

Latinos are individuals with personal and family roots in Latino-American countries. Many Latinos speak Spanish and most partake of the blended cultural traditions of the Spanish colonists and the indigenous peoples of the Americans. Latinos may belong to any racial group including those with roots in Europe, Africa, Asia, and the Middle East (p. 256)

Organista and Munoz (1996) further explain the differences, similarities, and complexities within this ethnic minority:

We fully recognize that each Latino is in some ways like no other Latino, and that there are subgroups of Latinos that are quite different from one another. Nevertheless, there are elements of shared history, of language, customs, religion, and moral values, and of self-identity and identity attributed by others, which define, however imperfectly, a recognizable subgroup in society which must be properly served. The more clinicians know about a particular subgroup of Latinos (e.g., Mexican Americans, Puerto Ricans, etc.), the more they can conceptualize and treat the mental health problems of the group in a culturally sensitive manner (p. 255)

These descriptions emphasize the challenges that psychologists may face when working with Hispanic/Latino groups and the broad awareness they need to have about the historical and social experiences of this group of clients.

Hispanics/Latinos' Mental Health

Under any circumstance, immigration can be traumatic and may lead to the loss of loved ones and extended family networks, to discrimination, to difficult living conditions, and to stress in adapting to the new culture, language, and customs. Given these stressors Hispanic/Latino immigrants are at a risk for mental and/or emotional problems, particularly depression, anxiety, post-traumatic stress, and substance abuse (American Psychiatric Association [APA], 2007). However, the quality of mental health services has not kept pace with the fast growth of Hispanics/Latinos in the U.S. They experience underutilization and disparities in mental health care (APA, 2007) when compared with individuals in the non-Latino White group (USDHHS, 2007). Hispanic/Latino immigrants are at greater risk of having their mental health needs unmet than are Hispanic/Latinos born in the U.S. (Vega & Lopez, 2001). They are underserved or inappropriately served (USDHHS, 2001), underrepresented in outpatient treatment, have

less access to evidence-based treatments, benefit less from psychotherapy, and drop out from treatment at a higher rate than non-Hispanic/Latino Whites (Alegria et al., 2002; Schraufhagel, Wagner, & Byrne, 2006; USDHHS, 1999, 2001). Pumariega (2007) suggested that there is also double discrimination facing Hispanics/Latinos in the U.S. when they are diagnosed with emotional disturbance or mental illness, because they already feel discriminated against by being an immigrant or being Hispanic/Latino. Recent studies have shown that mental health programs are not successful in reaching Hispanics/Latinos' need of treatment (APA, 2007) and that socioeconomic and cultural differences are the two main factors associated with these difficulties (USDHHS, 2001).

Moreover, the stress associated with the acculturation process may have an impact on mental health among Hispanics/Latinos immigrants (Sue & Chu, 2003); furthermore, the current national debates around immigration add to the adverse climate surrounding this population that already experience double discrimination (Pumariega, 2007). This suggests that given their propensity to experience financial, social, and occupational hardship, and cultural adaptation challenges, Hispanics/Latinos are at high risk for depression.

The cultural match theory suggests that Hispanic/Latino clients tend to adhere to and benefit more frequently from treatment interventions that agree with their beliefs (Hall, 2001; Sue, 1998, Sue 2003), and often reject those mental health services (e.g., traditional medical model) that do not embrace their cultural values. The lack of bilingual or Hispanic/Latino mental health providers also makes it difficult for this population to receive appropriate and effective treatment (APA, 2007). Thus, the development of culturally sensitive psychotherapies is needed to facilitate the delivery of

treatment services that are empathetic to Hispanics/Latinos' beliefs and values. Cultural factors not only help clinicians appreciate the vulnerability of their clients but they also help identify powerful sources of emotional resilience. Palloni and Morenoff (2001) referred to the *Hispanic paradox*, suggesting that despite the economic and social obstacles that Hispanics/Latinos face in this country, they appear to be resilient to a range of negative health outcomes (e.g., infant mortality, low birth weight), when compared to non-Latino Whites and other groups. The literature identifies several cultural values, including *familismo*, that help explain and understand the Hispanics/Latinos' resilience. *Familismo* refers to emphasis on family relationships that provide social support and protects against depression, even when the individuals experience severe environmental hardship. Plant & Sachs-Ericsson (2004) noted that interpersonal functioning may also protect Hispanics/Latinos against depression at a higher rate than for non-Latino Whites.

Other cultural values relevant to Hispanics/Latinos' resilience include faith (*fe*) and religious rituals (*rituales religiosos*). Interestingly, their religion and spirituality may also contribute to their stigma of mental illness, which prevents them from seeking professional help. Hispanics/Latinos tend to believe that mental illness or emotional disturbances are the result of spiritual crisis associated with personal transgressions or sins (*pecados*) against God, or against family members (Pumariega, 2007). Some Hispanics/Latinos associate mental illness with supernatural forces, such as "the evil eye" (*mal de ojo*) or spells placed on the ill person (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002), which lead these individuals to consult traditional healers (*curanderos*) or their priests. Hispanics/Latinos also associate mental illness with being "crazy" (*loco/loca*) and requiring long-term confinement (Martinez-Guarnaccia, 2007). As a

result, families may experience shame about having a mentally ill relative. They may perceive mental illness (e.g., depression) as a sign of personal weakness, which prevents them from accessing mental health services. They prefer to seek help from physicians, traditional healers (e.g., *curanderos*, *santeros*, *yerberos*, *espiritistas*), close friends, extended family members (e.g., *comadre* or *compadre*), and priests or ministers (APA, 2007; Pumariega, 2007; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Some of these individuals turn to alcohol or drugs to alleviate their depression or anxiety, adding complexity to their emotional problems.

Understanding Hispanics/Latinos' Cultural Values and Practices

Organista (2000) stated that despite the diversity of Latino groups in the U.S., they share common elements, including their family roots in Latin American countries, their Spanish language, and their cultural traditions resulting from the blend of Spanish colonists and the indigenous peoples of the Americas. In recent years, several scholars and researchers (Comas-Diaz, 1997; Falicov, 1998; Flores, 2000; Marin & Marin, 1991; Mezzich, Ruiz, & Munoz, 1999; Santiago-Rivera, 2003; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002) have emphasized the fact that psychologists need to be aware of the potential implications of certain cultural characteristics found within the Hispanic/Latino community in order to guide their interpersonal behaviors during the delivery of treatment services. These experts agreed in identifying the following cultural values as commonly shared by Hispanics/Latinos:

Familismo (*familia*) – It is one of the most important cultural value among Hispanics/Latinos, by which they place a high value on family tradition, unity, and loyalty (Mezzich, Ruiz, & Munoz, 1999). The Hispanic/Latino family (*la familia*) is a

close-knit group and the most important social unit that goes beyond the nuclear family. The father is considered the head of the family (*el jefe de la familia*) and the mother is responsible for taking care of the home (*la ama de casa* or *la senora de la casa*).

Traditional Hispanic/Latino families are hierarchical, with special authority given to elderly, parents, males, older siblings, and authority figures. Children are taught to be obedient and give deference to parents and authority figures because of their important hierarchical position (Hildebrand, Phenice, Gray, & Hines, 2000; Mezzich, Ruiz, & Munoz, 1999). Family ties (*lazos familiares*) are very strong and powerful among Hispanics/Latinos. The reputation and the wellbeing of the family unit prevail over the individual. Traditionally, *la familia* includes not only parents and children but also extended family members, the relatives (*los parientes*). Marin (1991) defined *familismo* as the perceived obligation to provide support to the members of the extended family, to reliance on relatives for help and support, and to an emphasis on interdependence. In this sense, family members assume the moral responsibility to help other family members that may experience life struggles (e.g., unemployment, diminished health conditions, financial difficulties). The attachment to the nuclear family includes the preference for living near family members and the shared responsibility in rearing children. As noted by Santiago-Rivera (2003), *familismo* remains very strong among Hispanics/Latinos across generations, regardless of how long they have lived in the U.S. It is a cultural value that derives from a collective worldview. Because the family (*la familia*) is the primary source of support, help and advice are usually sought from the family system first and important decisions, such as health conditions and treatment interventions are considered family matters.

A unique manifestation of *familismo* in the Hispanic/Latino culture is the *compadrazgo*, which is a powerful godparentage relationship that can be attributed to the Spanish colonization era (Santiago-Rivera, Arredondo, & Gallardo Cooper, 2002). The godparents (*padrinos / compadres*) play a very important role within the Hispanic/Latino family system. The godfather (*padrino / compadre*) and the godmother (*madrina / comadre*) become “co-parents” through a formal religious ceremony (e.g., baptism, first communion, confirmation), which gives them the right to help rear a child or children in the family (Santiago-Rivera, 2003). Family gatherings and celebrations, termed “rituals” by Falicov (1998), are also prominent expressions of *familismo*. These rituals refer to nuclear and extended family members (e.g., grandparents, aunts, uncles, cousins, *compadres / godparents*) coming together to commemorate special traditions or customs (e.g., Sunday meal, birthdays, anniversaries, baptism, first communion).

Machismo and ***Marianismo*** – Gender roles are clearly differentiated in the Hispanic/Latino culture. Men are expected to be “macho” and women “submissive” (Mezzich, Ruiz, & Munoz, 1999). *Machismo* is a traditional gender role expectation that describes Hispanic/Latino men as strong, dominant, possessive, sexist, and dominant. This negative portrayal of Hispanic/Latino men is pervasive in the U.S. and is commonly associated with violence towards women (Santiago-Rivera, 2003; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). However, *machismo* has a different meaning within the context of the Hispanic/Latino family system, in which the role of the man is centered on the responsibility of protecting, providing, and defending his family (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). In this sense, *machismo* suggests expectations that Hispanic/Latino men be family-oriented, hardworking, brave,

and protective of the welfare of his love ones, which Falicov (1998) considered honorable behaviors. *Marianismo* is a traditional gender role expectation that describe Latino/Hispanic women as virtuous, nurturing, practicing devotion, and self-sacrificing virtues inspired by the Virgin Mary. The cultural expectation for Hispanic/Latino women is to “put up with” (*aguantar*) undesirable family situations with submission (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). When they marry and become mothers, Hispanic/Latino women are supposed to protect and sacrifice themselves for their husbands and children. They are also responsible for providing spiritual strength to family members (Santiago-Rivera, 2003). They are considered the center of the family and in charge of the family’s health. Interestingly, the level of acculturation and level of education tend to influence change in traditional gender-role expectations among Hispanics/Latinos because higher level of acculturation and the higher level of education lead to the endorsement of less traditional gender-role behaviors. This change varies over time and is different between and among generations.

Religion (*religion*) and **Fe** (faith) – Hispanics/Latinos are primarily Roman Catholic and the Church is a major influence in their family lives and community affairs. Religious beliefs provide spiritual meaning to their lives. Hispanics/Latinos invoke their faith (*fe*) in a higher power to find comfort and make sense of adversity (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). *Dichos* (proverbs), such as “*En las manos de Dios*” (In God’s hands); “*Dios sabe lo que hace*” (God knows best); “*Es la voluntad de Dios* (It is God’s will); “*Que sea lo que Dios quiera*” (Let it be what God wants); and “*Dios proveera*” (God will provide) illustrate the way in which Hispanics/Latinos accept unfortunate life circumstances that escape their control. Scholars in the field (Santiago-

Rivera, Arredondo, and Gallardo-Cooper, 2002) have cautioned scientists not to make fatalistic attributions by describing Hispanics/Latinos as individuals who assume a surrendered view of their life circumstances. Any consideration of religious beliefs among Hispanics/Latinos should be done within the context of spirituality.

Respeto (respect) – Hispanics/Latinos place a high value on interpersonal relationships by embracing the quality of *respeto*. This is a quality demonstrated in all interpersonal relationships. *Respeto* incorporates diplomacy and tactfulness and discourages confrontation (Mezzich, Ruiz, & Munoz, 1999). It is a manifestation of deference to authority or hierarchical relationship (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). Traditionally, Hispanics/Latinos are expected to show respect (*respeto*) and be respectable (*respetable* or *bien educado*) or well-mannered by following the family values without creating shame (*verguenza*).

Formalidad (formality) – Hispanics/Latinos practice formality in their communication and interaction with others. The Spanish language provides two different pronouns to address someone in a formal (*usted*) or nonformal (*tu*) manner for the pronoun *you*. Because of this respect, individuals address each other as *usted* (formal *you*) and permission from the other person is needed before addressing that person as *tu* (nonformal *you*). Moreover, to address the elderly, Hispanics/Latinos use titles of higher respect: *Don* for elderly males and *Dona* for elderly females. These titles are followed by the person's first name. The common greeting practice is a firm handshake; however, a hug and a kiss on the cheek are also common greeting practices between a man and a woman, and between women (not between men), who are close friends or family members.

Carino (warmth, affection) – Hispanics/Latinos demonstrate affection in verbal and nonverbal manifestations, embracing the personal characteristic of being *carinoso* or *carinosa*. To express *carino* and communicate an endearing message, the Spanish language allows the change of the meaning of a word by adding the suffix *ito* or *ita* to nouns (Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). The suffix is added to nouns or words, changing their meaning to a diminutive that reflects a deeper expression of affect. For instance, the name *Rafael* can be changed to *Rafaelito*, and *Inez* to *Inezita*. Hence, clinicians and doctors should not be surprised when their Hispanic/Latino clients address them as *doctorsito* (male doctor) or *doctorsita* (female doctor). Moreover, greeting someone with a hug or/and a kiss on the cheek are nonverbal manifestations of *carino* among Hispanics/Latinos.

Simpatia (good nature and pleasant attitude) – A pattern of social interaction and verbal communication that emphasizes a pleasant demeanor aimed to promote agreement and reduce or avoid conflict (Mezzich, Ruiz, & Munoz, 1999). It implies a common desire to have a warm and pleasurable social relationship by promoting smooth communication, conformity, and cooperation (Marin & Marin, 1991; Santiago-Rivera, 2003).

Personalismo – A pattern of social interaction that implies “personalized” attention towards the client (Interian & Diaz-Martinez, 2007) as well as warm, friendly, and interpersonal relationship (Mezzich, Ruiz, & Munoz, 1999). Hispanic/Latino clients seek to interact with individuals rather than with institutions. Both *simptia* and *personalismo* are characteristics of a collective worldview.

Dichos* or *refranes (proverbs) – Hispanics/Latinos often use terms and expressions that relate to some truth and folk wisdom with the purpose of providing encouragement and advice to others in times of difficulty. Interian & Diaz-Martinez, (2007) suggested that *dichos* may be used in treatment as an effective way to communicate therapeutic messages.

Desahogo (getting things off one's chest) – Many Hispanic/Latino clients believe that the purpose of psychotherapy/treatment is to have the chance for *desahogo* (Martinez-Guarnaccia, 2007), which implies that they seek to narrate their problems, thoughts, or events in a detailed manner, without time restrictions (Interian & Diaz-Martinez, 2007)

Puntualidad (punctuality/time orientation) – Hispanics/Latinos focus on here-and-now rather than detailed planning of future activities. They are more relaxed and flexible about time, and not being on time is a socially acceptable behavior (Mezzich, Ruiz, & Munoz, 1999). Given the fact that punctuality is not a standard practice among Hispanics/Latinos, being late for an appointment is not indicative of disrespect.

Acculturation and Cultural Adaptation

Acculturation is the adaptation, variable defined as the changes that individuals experience as a result of being in contact with other cultures. The person's traditional cultural beliefs are replaced by those of the new culture. Santiago-Rivera (2003) conceptualized acculturation as a socio and psychological phenomenon that implies complex processes of change and adaptation. Marin (1992, 1993), a pioneer in the study of acculturation among Hispanics/Latinos, described three levels associated with this process of learning, change and adaptation: (1) the basic level, in which

Hispanics/Latinos may forget their culture of origin's important historical events of traditions while learning about the new culture; (2) the intermediate level, in which Hispanics/Latinos may lose Spanish language proficiency; and (3) the profound level, in which Hispanics/Latinos' core values and beliefs may change. These changes occur over time (Trimble, 2003), causing challenges and demands that may lead to acculturative stress, which is considered a risk factor for Hispanics/Latinos in the development of their physical and psychological problems (Kouyoumdjian, Zamboanga, & Hansen, 2003), including depression. The literature indicates that acculturative stress may be pervasive and long lasting if not treated during early adaptation stages, which is the time when clients may be more vulnerable. The early optimism and idealization of a better future in America experienced by newly arrived immigrants fades when they start facing negative experiences and psychosocial barriers. Newly arrived immigrants have no choice but to cope with these stressors in order to adapt to the new environment.

Research on the relationship of depression and social interest (Miranda & Umhoefer, 1998) identified three levels of acculturation: (1) low-acculturation level, defined as strong affiliation with nationality group and rejection of the host culture's practice; (2) bicultural level, defined as integration of cultural beliefs, values, and behaviors of both the culture of origin and of the host culture; and (3) high acculturation level, defined as strong affiliation with the host culture and weak affiliation with the culture of origin. In their study, Miranda & Umhofer (1998) found that lower-acculturated individuals reported higher rates of depression and lower social interest, and bicultural individuals reported lower depression and higher social interest. These findings suggest that bicultural individuals may be able to cope with adaptation better and

may not seek mental health care, whereas lower-acculturated individuals, who remain more closely affiliated with their cultural values and beliefs, may experience higher need for mental health care because of depression.

Cultural adaptation refers to the mastery of particular sets of functional skills and the key to psychological well-being, which allows individuals to perform successfully when challenged with cultural tasks or when asked to fulfill specific roles in society (LaFombrose, Coleman, & Gerton, 1993). When culturally adapted, individuals develop self-efficacy, self-worth, and specific styles of living that help them negotiate with life events (Tyler, Brome, & Williams, 1991). *Intercultural competence* or the ability to function in a particular culture is a unique aspect of cultural adaptation and is different from acculturation (Zea et al., 2003). Torres and Rollock (2007) theorized that intercultural competence implies the development of strategies that characterize individuals' culture of origin and facilitate achievement of meaningful tasks. Therefore individuals from ethnic minority groups are considered interculturally competent when they develop skills for self-management and for negotiation with the mainstream culture from within the frameworks of practices, beliefs, and values of their traditional culture.

Acculturation and Gender Roles

The literature reveals that from both cultural and psychological perspectives, acculturation is multidimensional, ongoing, and occurs across generations (Berry, 2002). Therefore it is important to understand how the acculturation process may influence changes in Hispanics/Latinos' gender roles expectations and may cause conflicts in their relationships. The support of women's right in America society has impacted the life of Hispanic/Latino males and females living in the U.S. (Santiago-Rivera, Arredondo, &

Gallardo Cooper, 2002). The literature suggests that Hispanic/Latino women experience more rapid changes than do men in their beliefs about gender role expectations, which can lead to relational, family, and identity conflicts. However, it is still argued that *Marianismo* remains a Hispanic/Latino cultural value.

The traditional dynamic in Hispanic/Latino families is that women appear to be highly dependent on their husbands, who tend to support the dynamic that preserves their role of authority and protector in the family. However, clinicians are cautioned about stereotyping Hispanic/Latino women as passive or submissive. On the contrary, they fulfill a challenging and highly demanding role which defines them as the “silent power in the family” (Santiago-Rivera, Arredondo, Gallardo-Cooper, 2002). When trying to assess how the dynamic of gender role expectations may influence the therapeutic relationship between traditional male Hispanic/Latino clients and female therapists, clinicians must consider that throughout their lives, Hispanic/Latino men are used to being nurtured and taken care by female figures (e.g., grandmothers, mother, sisters, aunts, and wife). Thus they may be receptive to female therapists that display a nurturing approach. Although traditional gender roles are more evident among recent Hispanic/Latino immigrants, they will eventually experience transformation as a result of adapting to their new ways of life. The transformation takes place over time and is different from one generation to the next. Culturally tailored mental health interventions may help these clients navigate through these changes.

In summary, as the fastest growing ethnic minority group in the U.S., Hispanics/Latinos provide the opportunity for psychologists to study those strengths that promote well-being and successful cultural interactions. Therefore, the treatment of adult

Hispanics/Latinos diagnosed with depression should give consideration not only to acculturation variables, but most importantly it should also identify those factors that impact their cultural interactions or intercultural competence. It is relevant that psychologists assess how their Hispanic/Latino clients interact with the mainstream and traditional cultural groups and how they implement cultural strategies of interacting with their environment, because cultural values or beliefs delineate those resources that are needed to be implemented in order to meet adaptation demands and the consequences for the specific adaptation style (Hobfoll, 1998). Berry (2003), postulated that a dominant society that does not accommodate to the needs of acculturating individuals jeopardizes the success of the adaptation. Torres and Rollock (2007) emphasized the fact that susceptibility to depressive symptoms among Hispanics/Latinos may be influenced by their capacities to accommodate and patiently adapt to the new mainstream culture by selectively using specific, valued traditional cultural patterns. As a result, their acculturation goals become crucial in their cultural adaptations because they influence the mainstream variables that they choose to incorporate into their lives, as well as the coping skills available to them when negotiating with the environment. Weigartner, Robison, Fogel, and Gruman (2002) theorized that the presentation of mood symptoms across ethnic groups is a unique experience and to appreciate it, psychologists must be sensitive to the different formulations and perceptions of what it means to experience such difficulties. Torres and Rollock (2004) affirmed that the cultural adaptation of Hispanics/Latinos is better understood when there is consideration for their abilities, group-specific strengths, and community support they have available when interacting in the mainstream American culture. Therefore acculturation and cultural adaptation play

relevant roles in Latinos' well-being, in their moods, and in the ability to function and adjust to demands of life in U.S. society. Furthermore, Torres and Rollock (2004) stated that intercultural competence helps predict acculturative stress and depression among Hispanics and that greater proficiency in group-specific skills is associated with lower levels of distress among Hispanics adjusting to the U.S. culture

Depression

Depression can be a pervasive and debilitating mental disorder. The diagnosis of depression is often used in the broad sense to describe a syndrome that includes a constellation of physiological, affective, and cognitive manifestations that may lead to distress and impairment. As defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV-TR, American Psychiatric Association, 2000), depression is a mood disorder. The primary subtypes of depressive disorders are major depressive disorders and dysthymic disorders, and there are variations in the number of symptoms, their severity, and persistence within these classifications. *Major or acute depressive disorder* is characterized by one or more major depressive episodes that occur for a period of at least two weeks, and represent a change from previous behavior or mood. Although there is a combination of symptoms leading to the diagnosis of major depression, depressed mood and loss of interest or pleasure must be present. These symptoms tend to interfere with the individual's ability to work, study, sleep, eat, and enjoy activities that used to be pleasurable to that individual. *Dysthymic disorder* or *chronic depression* is a less severe type of depression characterized by many of the same symptoms that occur in major depression, but are less intense and last much longer, at least two years. Although the long-term symptoms associated with dysthymic disorders are not disabling, they tend to keep the individual from feeling good or functioning well (National Institute of Mental Health [NIMH] 2000). Because of the duration of the symptoms, dysthymia can be described as a "veil of sadness" that shadows most of the individual's activities. Unlike individuals with major depression, those who suffer from dysthymia may not exhibit marked changes in mood or in daily

functioning. However, they experience low energy, general negativity, and a sense of dissatisfaction and hopelessness. Individuals with dysthymia also experience major depressive episodes at some time in their lives.

Prevalence

The National Institute of Mental Health (NIMH, 2006) has reported that an estimate of 20.9 million American adults, or about 9.5 percent of the U.S. population age 18 and older, has a mood disorder in any given year, yet only 1 in 10 will ever seek treatment. The median age onset for mood disorders is 30 years. Within the classification of mood disorders, *major depressive disorder* is the leading cause of disability in the U.S. for ages 15 to 44 (NIMH, 2006; World Health Organization [WHO], 2004), affecting approximately 14.8 million American adults, or about 6.7 percent of the U.S. population ages 18 and older every year. Although major depressive disorder can develop at any age, the median age at onset is 32 with higher prevalence in women than in men. *Dysthymic Disorder* affects approximately 3.3 million American adults, or about 1.5 percent of the U.S. population 18 and older in any given year. The median age of onset of dysthymic disorder is 31. Suicide rates are often linked to diagnosable mental disorders such as depressive disorder. The literature indicates that more than 90 percent of individuals who kill themselves have a diagnosis of a depressive disorders or substance abuse, and an estimate of 32,439 individuals, that is, 11 per 100,000, died by suicide in the U.S. in 2004 (NIMH, 2006).

The American Psychiatric Association (1994) defined depression as one of the most common mental illnesses affecting millions of Americans each year. It is a pervasive and impairing illness that affects both women and men; however, women

experience depression at twice the rate of men (Dubovsky, Davies, & Dubovsky, 2003; NIMH, 2005; U. S. Department of Health and Human Services [USDHHS], 2001). In the United States, approximately 6 million men suffer from depression each year and many of them do not pursue mental health care for this treatable condition (USDHHS, 2001; Wang, Berglund, & Kessler, 2000). Several studies (Addis & Mahalik, 2003; Gonzales, Alegria, & Prihoda, 2005; O'Brien, Hunt, & Hart, 2005) showed that men tend to hold more negative attitudes toward mental health treatment than women, and are less likely to seek care for mental health conditions in general, including depression. Epidemiological studies (USDHHS, 2001) on the U.S. population have found that women are 2 to 4 times more likely than men to be diagnosed with depression, whereas men tend to report higher substance abuse than women and are 2 to 4 times more likely to commit suicide. These findings suggest that men and women experience and exhibit depressive symptoms in different ways. Men are prone to report fatigue, irritability, loss of interest in pleasurable activities, and sleeping problems, and to externalize their depressive symptoms by becoming frustrated, angry, and abusive. Some men abuse alcohol or drugs as a mechanism of self-medication, which makes the diagnosis of depression more severely challenging (Moller-Limkuhler, 2002). The Centers for Disease Control and Prevention (2004) has reported similar prevalence in the U.S. Hispanic/Latino population.

Diagnosis

The diagnosis of depression includes: (1) depressed mood most of the day, nearly every day; (2) markedly diminished interest or pleasure in all, or almost all, activities most of the day, nearly every day; (3) significant weight loss when not dieting or in

weight gain, or in decrease or increase in appetite nearly every day; (4) insomnia or hypersomnia nearly every day; (5) psychomotor agitation or retardation nearly every day; (6) fatigue or loss of energy nearly every day; (7) feelings of worthlessness or excessive or inappropriate guilt (which may be delusional) nearly every day; (8) diminished ability to think or concentrate, or indecisiveness, nearly every day; and (9) recurrent thoughts of death, recurrent suicidal ideation without a specific plan, or a suicide attempt or a specific plan for committing suicide (DSM-IV-TR, 2000). For a diagnosis of major depressive episode, the *DSM-IV-TR* (2000) text revision requires that at least five of the symptoms listed above must be present during the same two-week period and that the symptoms represent a change from the individual's previous functioning, with one of the cardinal symptoms being either (1) depressed mood, or (2) loss of interest or pleasure.

Depression Impacts Individuals' Quality of Life

Depression is a treatable condition that, when left unattended, can lead to reduced functioning, poor quality of life, and increased morbidity (World Health Organization [WHO], 2001). Depression is considered a leading cause of disability worldwide (Murray and Lopez, 1996) and represents a serious public health problem (USDHHS, 2007). Depression has adverse effects on relevant areas of human functioning, including familial, parental, and work roles. Murray and Lopez (1996) argued that there is an intrinsic relationship between depression and performance role and emotional functioning, and between depression and health problems. For instance, depression impairs individuals' roles and emotional capacities to successfully pursue and attain employment. This impairment may trigger secondary stressors and changes in coping mechanisms, with subsequent impacts on mental health and functioning that may

intensify depression and impair functioning. Furthermore, comorbidity with substance abuse, anxiety disorders, somatoform disorders, and hypochondriasis often add a constellation of physiological manifestations to depression (Mineka, Watson, & Clark, 1998). It is not uncommon to find increased levels of somatic pain among individuals who suffer depression.

Broadhead, Blazer, George, & Tse (1990) found that the prevalence of mild depression was associated with 51% more days lost from work than was major depression. Depression, therefore, has a significant impact on the economy by diminishing productivity and by exacerbating the use of health care resources (Greenberg, Stiglin, Finkelstein, & Berndt, 1993), which includes higher rates of emergency room use, use of medications, medical consultations for emotional problems, attempted suicide, and days lost from work (Glied, & Kofman, 1995).

Depressed individuals are more likely than others to visit a physician for some other reason, seeking less stigmatized explanations for their difficulties. These individuals often undergo extensive and expensive diagnostic procedures and receive treatment for several other complaints, yet their depression remains untreated or underdiagnosed. As a result, depression is associated with poor quality of life and overutilization of health care that leads to excessive expenditures (Unutzer, Katon, Simon, Walker, Grembowski, & Patrick, 1996), with many individuals receiving no psychological treatment or inadequate treatment in primary care settings. Depression is also associated with higher medical costs, greater disability, poor self-care, poor adherence to medical regimens, and increased morbidity and mortality from medical illness (Katon & Sullivan, 1990; Frasure-Smith, Lesperance, & Talajic, 1993). In the

absence of treatment, symptoms of depression can last for weeks, months, or years, and may lead to suicide. The severe impairment in social and physical functioning caused by depression is considered a major precipitating factor in suicide. Moreover, because depression tends to be a recurrent disorder, many individuals who have experienced previous episodes will be at higher risk.

Psychosocial Variables Associated with Depression

Treatment can alleviate the symptoms of depression, yet because it often goes unrecognized, depression continues to cause unnecessary suffering. The barriers to the diagnosis of depression reflect the nature of the disorder in a complex medical and psychosocial context. Although depression is a pervasive and debilitating mental disorder that affects *all* racial, ethnic, and socioeconomic backgrounds, the impact of human suffering and loss of productivity caused by this disorder often hurt the most vulnerable, such as individuals of low-income and of ethnic minority groups. Intense depressive symptoms are particularly common among: (a) individuals with economic problems and those of lower socioeconomic status; (b) individuals who are less well educated and unemployed; and (c) individuals within ethnic groups. Some studies (McGrath, Keita, Stickland, & Russo, 1990) have shown that women within these ethnic groups are more likely than Caucasian women to share a number of socioeconomic factors for depression, including racial discrimination, lower educational and income levels, segregation into low status and high-stress jobs, unemployment, poor health, large family sizes, marital dissolution, and single parenthood. Moreover, the severity of depression is often higher among individuals confronting the impact of immigration and acculturation (National Center for Health Statistics, 1994).

Taken together, these points emphasize the fact that depression is a major health problem that requires a combination of prevention and treatment services, with focus on increasing individuals' abilities to regulate their moods (Gross & Munoz, 1995; Munoz, 1995), ensuring quality treatments methods for individuals regardless of their socioeconomic status.

Hispanics/Latinos and Depression

Researchers (Vega, Sribney, Aguilar-Gaxiola, & Kolody, 2004) have found that major depression is as prevalent among Latinos as among non-Latino Whites. However, Hispanics/Latinos diagnosed with depression are less likely to seek mental health care for depression in a timely fashion, less likely to receive comprehensive medical care, and less likely to access specialty mental health services, when compared with non-Hispanic/Latino Whites (Institute of Medicine, 2003; U. S. Department of Health and Human Services [USDHHS], 2001; Vega, Kolody, Aguilar-Gaxiola, & Catalano, 1999). These vulnerabilities seem to be associated with sociocultural barriers that interfere with Hispanics/Latinos' attitudes toward treatment-seeking and are considered determinant in the underutilization and disparities of their mental health care, including the lack of bilingual providers, unavailability of health insurance, lack of culturally compatible mental health services, and Hispanic/Latinos' beliefs about mental health and mental illness (Miranda, Lawson, & Escobar, 2002). Cabassa, 2007; O' Brien et al., 2005; USDHHS, 2001) suggested that inequities in the care of depression among Hispanics/Latinos in the U.S. are attributed to financial barriers, lack of knowledge about depression and its treatment, and lack of recognition about the disorder as a treatable illness.

Hispanics/Latinos' attitudes toward mental health treatments prevent them from pursuing professional services (Cooper et al., 2003; Givens, Houston, Van Voorhees, Ford, & Cooper, 2007; Ortega & Alegria, 2002). These attitudes may include: feeling uncomfortable or not wanting to discuss emotional problems outside their family system, being ashamed to discuss emotional troubles, believing that antidepressants are addictive and embracing self-reliance as a coping mechanism. In a more recent study on Hispanic/Latino immigrants' intentions to seek care for depression, Cabassa and Zayas (2007) found that Hispanic/Latino patients' preferences were to rely first on informal sources of care (e.g., family member, friend, priest, minister), and then seek formal sources to overcome depression (e.g., social worker, primary health care doctor, psychiatrist). Hispanics/Latinos seek specialized mental health services when their problems do not improve or become chronic. Cabassa and Zayas' study also showed that after controlling for demographics, health insurance status, acculturation, clinical characteristics, past service use, and perceived barriers to care, Hispanic/Latino immigrants' help-seeking attitudes for depression were associated with their views of depression, attitudes towards their doctors' interpersonal skills, and social norms related to seeking professional care. Peifer, Hu, and Vega (2000) found that Puerto Rican, Mexican, and Cuban men were less likely than women to seek medical or mental health care. Cabassa (2007) indicated that Hispanic/Latino men "viewed depression as a serious debilitating condition that would improve with time and could be controlled through either personal efficacy or treatment" (p. 504). Therefore it is important that clinicians explore and understand their Hispanic/Latino clients' views of their depression, including how those views influence their participation in treatment. As Cabassa (2007) noted:

Clinicians treating Latino immigrant men should consider actively eliciting perceptions about the causes, course, consequences, and perceived controllability of the illness. Clinicians can use the perceptions to negotiate and develop a treatment plan that is congruent with men's views of depression (p. 504).

Given the fact that the promptitude and appropriateness of mental health care for depression depend on the individual perception, belief, and attitude toward the mental disorder and its treatment, Cabassa (2007) postulates that one way to empower Hispanic/Latino clients is providing them with the necessary information and the means that help them identify depression and their options for treatment. Taking the time to assess and understand Hispanics/Latinos' experiences with depression, with their beliefs, and their attitudes may facilitate the development and implementation of culturally sensitive interventions directed to promote their help-seeking behavior, enhance the therapeutic alliance, and improve treatment adherence.

The literature indicates that Hispanics/Latinos are often amenable to treatment and tend to prefer psychotherapy or combined counseling and medication rather than pharmacotherapy alone (Lewis-Fernandez, Das, Alfonso, Weissman, & Olfonso, 2005). Dwight-Johnson, Lagomasino, Aisenberg, and Hay (2004) noted that low-income Hispanics/Latinos preferred a combined treatment of psychotherapy and medication, over either approach alone. However, Cabassa, 2007; Cooper et al., 2003; Dwight-Johnson, Sherbourne, Liao, & Wells, 2001 found that Hispanics/Latinos prefer psychotherapy/counseling over medication, because of their beliefs that antidepressant medications can be addictive and make them feel drugged. These findings suggest that Hispanics/Latinos' beliefs may not only prevent them from seeking mental health services, but may also lead them to non-compliance with antidepressant medications, or

may trigger early withdrawal from treatment. Psychologists must enhance their interventions by facilitating the education of their Hispanic/Latino clients with the understanding of their depression, of treatment goals, and of treatment expectations; otherwise, poor communication between these clinicians and their Hispanic/Latino clients about their depression and their treatment alternatives can lead to non-compliance with and non-adherence to treatment (Sleath, Rubin, & Huston, 2003). Lewis-Fernandez, Das, Alfonso, Weissman, and Olfonso (2005) emphasized the fact that to effectively assess Hispanic/Latino clients' understanding of their depression and treatment plans, clinicians should assess their clients' explanatory models of the illness, identify the social and financial barriers to adherence, and address fears and concerns about treatment.

Treatment Considerations

Fortunately, depression is very treatable, with over 80 percent of those who seek treatment showing improvement (NIMH, 2005). Depending on the pattern of severity, the persistence of the symptoms, and the history of illness, appropriate treatment involves antidepressant medication, psychotherapy, or a combination of both. There are several treatment approaches that are considered effective in the treatment of depression. Cognitive-Behavior Therapy (CBT) is one of two of the most effective short-term psychotherapeutic methods, supported by research studies for the treatment of some forms of depression. The other psychotherapeutic approach is Interpersonal Therapy (IPT) (NIMH, 2000). Cognitive-Behavior Therapy (CBT) targets the individual's negative styles of thinking and behaving often associated with the depression. In the case of Hispanics/Latinos, CBT principles, such as being non-judgmental, focusing on strengths, and empowering the clients, can help them overcome feelings associated with

depression, particularly when confronting the impact of immigration and acculturation. This is not to say that these are the only causes of depression in Hispanics/Latinos, but to emphasize the uniqueness of their life circumstances which needs to be taken into account when providing psychological services. Furthermore, the educational approach, the focus on the present, and the embracing of the social context that characterize CBT approaches can also provide Hispanic/Latino clients with an understanding of their unique issues (Hays & Iwamasa, 2006).

At present, despite the efforts from some researchers to integrate cultural considerations into the practice of CBT, there is limited literature regarding the application to Hispanic/Latino populations of culturally sensitive CBT practice that addresses these clients' perceptions and attitudes toward such a treatment intervention. The present study will provide recommendations for the cultural adaptation of a CBT guidebook for clients with depression by integrating relevant Hispanic/Latino culture-specific variables and adapting CBT principles to suit those variables.

Cognitive-Behavioral Therapy

Cognitive-behavior therapy (CBT) is one of the major psychotherapeutic orientations (Roth & Fonagy, 2005) in modern times. This treatment model derives from cognitive and behavioral psychological models that include theories of normal and abnormal development, as well as theories of emotion and psychopathology. CBT operates under the principle that individuals' thoughts, beliefs, attitudes, and perceptual biases influence the emotions that they will experience and also the intensity of those emotions. CBT is an active, collaborative, structured, and time-limited psychotherapeutic model that embraces the relationships between thoughts, emotions, and behavior. In CBT, therapist and client work together in a collaborative effort to identify and change negatively biased and distorted thoughts that interfere with the ability to use rational problem-solving. The task of the therapist is aimed at helping clients overcome their difficulties by changing their thinking, and consequently modifying their behavior, and emotional responses (Reinecke, Washburn, & Becker-Weidman, 2007). The emphasis of the CBT model lies on the teaching and implementation of concrete, tangible, solution-focused, problem-solving, and present-oriented tools to change thoughts, reduce distress, and improve functioning.

The CBT model proposes that dysfunctional cognitions contribute to maladjustment, but that functional cognitions contribute to healthy adjustment. This psychotherapeutic model presumes that cognitions, which include perception, beliefs, and self-talk, are mediators of an individual's mood, behavior, and physiological reactions in response to his or her environment (Beck, 1995). The CBT model also postulates that individuals' beliefs or attributions are influenced by their social experiences and that their

dysfunctional behaviors develop in social contexts (Reinecke, Washburn, & Becker-Weidman, 2007). Greenberger & Padesky (1995) noted that CBT emphasizes five components to any problem: cognition (thoughts), mood (emotions), physiological reactions (symptoms and physical sensations), behavior, and the environment. Thus, the role of the CBT therapist is to help clients recognize and understand the continuous interactions between and among these five components. Clients then become aware of how their negative, distorted, and unrealistic thoughts can cause them distress (e.g., uncomfortable physical symptoms or sensations, maladaptive behaviors, uncontrollable emotions). They also learn to identify those social and physical aspects in their environment that add to their distress. The clients' awareness and understanding of these variables and their interrelations promote the development and implementation of coping strategies, such as problem-solving, social skills, and cognitive restructuring. The latter is the core strategy of CBT; this teaches clients to change the ways they think with the purpose of changing the ways they feel and behave. CBT is a focused therapy that seeks problem solution (White, 2000) and provides psychological empowerment to clients by helping them to see themselves, the world, and their future in a more realistic manner.

Fundamentals of Philosophy Relevant to CBT

The interest in human cognition can be traced to ancient Greeks who speculated on the nature of thinking. In this sense, the foundation of cognitive therapy principles can be traced back to Greek philosophers, such as Socrates, Plato, and Epictetus, whose philosophical teachings focused on the well being of individuals and the pursuit of happiness. They asserted the mind-body connection and emphasized the power of the mind (soul). These ancient philosophers marked the path on which modern psychology,

particularly cognitive therapy, would develop. For instance, Socrates (470-399 B.C.) embraced knowledge as a living, interactive thing. His famous philosophical ideas described the necessity of doing what one thinks is right even in the face of universal opposition and of the need to pursue knowledge even when opposed (Brennan, 2003). In *The Apology*, Socrates radically and skeptically claimed to know nothing at all except that he knew nothing. He formulated his method of philosophical inquiry that consisted in questioning people on the positions they asserted and working them through questions into a contradiction, thus proving to them that their original assertions were wrong. Socrates and Plato refer to this method of questioning as *elenchus*, which means something like "cross-examination." The Socratic *elenchus* eventually gave rise to *dialectic*, the idea that truth needs to be pursued by modifying one's position through questioning and conflict with opposing ideas (Brennan, 2003). According to Socrates, knowledge is the ultimate goal and leads to happiness. It is this idea of the truth being pursued that characterizes Socratic thought and much of what in modern times is called *Socratic Method* in CBT. The notion of *guided discovery* (dialectic) practiced in CBT is Socratic in nature and is conceived of as an ongoing process. That is, the truth is somehow attainable through the process of *elenchus*, which in CBT practices translates into *Socratic dialog*. CBT implements the Socratic Method initially by defining the client's critical issue at a general level, and then persistently questions the adequacy of the definition, eventually to advance logically to a clearer statement of the question in order to approach the resolution.

Plato (427-347 B.C) asserted the psychophysical concept of *mind-body dualism*, which in modern days is embraced by CBT practices (mind-body connection). Plato

formulated the idea that human activity was composed of two entities: mind and body, and that only the mind or soul could contemplate true knowledge. He theorized that body's imperfect contributions were those of sensations and that the influx of sensory data gave individuals a *percept*, which he defined as a unit of information about the environment (Brennan, 2003). Several important implications for CBT principles can be drawn from Plato's formulations of mind-body dualism and processing of information. He asserted that the activities of the mind were twofold, whereas *pure intellect* was the higher activity providing intuitive knowledge and understanding, *opinion* was formed through bodily interactions with the environment, which generated belief and conjecture (Brennan, 2003). These formulations lay the basis for what in CBT terms are known as cognitive distortions.

Epictetus (55 -135 A.D.) praised the fact that all human beings are perfectly free to control their lives and to live in harmony with nature. His philosophical teaching promoted principles of right conduct and true thinking (Long, 1991). He embraced the description of a calm and disciplined life, and the distinction between our ability to think or feel freely and our lack of control over external events or circumstances (Seddon, 2006). The essence of Epictetus' psychology can be appreciated in the anthology of his quotes: *The Enchiridion or Handbook*, which has influenced the development of modern philosophy and intellectual attitudes. He showed that reasoning can free individuals from constraints of absolutism and emotionalism, and, consequently, they can live a more productive and tranquil life (Long, 1991). The foundation of cognitive therapy systems can be traced to the values embraced by Epictetus (e.g., power of thoughts, percepts,

interpretations, daily regime of rigorous self-examination) as appreciated on some of his famous quotes in the Enchiridion (Long, 1991):

Of things some are in our power, and others are not. In our power are opinion, movement toward a thing, desire, aversion (turning from a thing); and in a word, whatever our own acts [italics added]: not in our power are the body, property, reputation, offices (magisterial power), and in a word, whatever are not our own acts (p. 11).

Men are disturbed not by the things which happen, but by the opinions about the things.... When, then, we are impeded or disturbed or grieved, lets never blame others, but ourselves, that is our opinions. It is the act of an ill-instructed man to blame others for his own bad condition (p. 14).

Remember that is not he who reviles you or strikes you, who insults you, but it is your opinion about these things as being insulting. When, then, a man irritates you, you must know that it is your own opinion which has irritated you. Try therefore in the first place not to be carried away by the appearance. For if you once gain time and delay, you will more easily master yourself (p. 22).

Epictetus asserts that when individuals understand what is in their power, they attain and maintain excellence in their way to understand what is in their power (Seddon, 2003).

Similar to Epictetus' teaching, CBT emphasizes that one's ability to control external events (things) is limited and partial; thus, individuals must learn to change themselves, change the way they regard external events, and what they hold to be of real value and importance. Individuals must learn to exercise their power on their thoughts about things, their intentions to act, what is worth pursuing and why is it worthwhile. Whereas, CBT teaches to identify cognitive distortions and to challenge automatic thoughts, Epictetus emphasizes individuals' need to learn how to make proper use of impressions to become free from anxieties, frustrations, and emotional upsets even in times of adversity (Seddon, 2003). When Epictetus states, "For another will not damage you, unless you choose: but you will be damaged then when you shall think that you are

damaged” (Long, 1991, p. 29); he asserts that the interpretation of this proverb is that when things or events become real and true to an individual, that is when his or her impressions become convictions. Individuals are prone to evaluate and interpret circumstances assenting to the proposition that something is good or bad for them, which Epictetus considered an error. That is, when individuals think that something is bad for them, their emotional responses will be of a negative nature (e.g., disappointment, anger, frustration). In CBT terms, the negative triad (negative view towards the self, the world, and the future) that characterizes the depressed individual may be understood in light of Epictetus’ concern with assenting to impressions of things being bad. Epictetus asserted that when individuals let their well-being (‘good flow’) rest on external things that are not in their power, and allow themselves to respond with disturbing emotions, they are courting disaster. As a result, he teaches that individuals replace their faulty impression by another that is ‘fair and noble’ (Seddon, 2003), which in CBT principles, can translate to cognitive restructuring.

Efficacy of CBT in the Treatment of Depressive Disorders

Cognitive theories postulate that the way in which individuals view and interpret stressful events may contribute to whether or not they become depressed. That is, the impact of a stressor is moderated by the unique meaning that the event or situation has for the individual. Depression arises from a cognitive state of helplessness, hopelessness, and entrapment (Beck et al., 1979; Reinecke, Washburn & Becker-Weidman, 2007; White, 2000). The key to understanding depression from a CBT perspective is that affect and behavior are determined primarily by the way in which individuals structure their world. This means that depression is a manifestation of a *cognitive triad* of errors and the

peculiar way in which individuals infer, recollect, and generalize their experiences (Beck et al., 1979).

Although depression can have many causes (e.g., biological changes, rigid negative attitudes about oneself, catastrophic events), negative thinking is the common denominator regardless of the etiology, which means that negative thoughts, beliefs, assumptions, and overly negative interpretation of events perpetuate depressed mood. CBT interventions with depressed clients are designed to teach them to identify and monitor their negative ways of thinking with the ultimate goal of modifying and restructuring their thinking patterns. By learning to identify their distorted automatic thoughts and to replace them with more realistic views, depressed individuals can reduce their symptoms of depression and the likelihood of experiencing new episodes (relapse). Based on the theoretical assumption that human behavior is learned, CBT treatment model focuses on helping clients develop and implement affect and cognitive regulation skills. CBT interventions include strategies, such as changing how people process information from their psychosocial environment (cognitive restructuring), skill building (problem-solving, communication skills), and mood regulation skills (behavioral activation) (Aeran & Cook, 2002). The effectiveness of CBT for the treatment of depression relies on its educational and collaborative approach, as well as on the client's efforts to comply with homework and to use the skills outside of therapy.

The basic aims of treatment in depressive disorders are to make acute symptoms more bearable, restore psychosocial functioning, and prevent recurrence. Although pharmacotherapy has been and remains the chief support of treatment, in some cases medication alone is not entirely effective and does not protect depression sufferers

against further episodes. Moreover, many patients prefer psychotherapy or counseling over medication for treatment of depression. There is evidence to support the efficacy and effectiveness of CBT to reduce clinical symptoms and improve quality of life across different clinical problems/mental health disorders. More specifically, CBT has demonstrated superior outcomes to antidepressants in the treatment of adults (Butler, Chapman, Formen, & Beck, 2006) and adolescents (Rohde et al., 2008). DeRubeis and Crits-Cristoph (1998) showed support for the long-term efficacy of CBT for depression in adults, whereas Rohde et al. (2008) found that a combination of CBT and antidepressant medication can achieve the highest rate of sustained improvement and prevent recurrence of major depression in teens. Specifically, Rohde et al. (2008) found that among 242 adolescents treated for major depression, 61 percent significantly improved by week 12, with 71 percent in the combined treatment group achieving the highest improvement, compared with 68 percent improvement in the antidepressant medication-only group, and 42 percent improvement in the CBT-only group. Interestingly, 89 percent of those in combination treatment maintained improvement through 36 weeks, whereas 74 percent of those in antidepressant medication-only group maintained improvement, and 97 percent of those in CBT-only group maintained improvement. These findings indicated that when initially responding to CBT, clients may benefit from CBT preventive effects that help them sustain improvement and potentially prevent relapse recurrence (NIMH, 2008).

In sum, as envisioned by Aaron Beck, CBT is a well-established treatment for unipolar depressive disorders, and there are general characteristics that make this treatment model a useful intervention for individuals with depressive disorders. Its structured, step by step approach helps clients develop a greater sense of control. Its

collaborative and educational style and the use of *guided discovery* make CBT an effective approach for individuals who seek an active psychotherapy that provides respect, information, and choice. These treatment characteristics are especially significant for treating depressed clients who experience distress, powerlessness, and who struggle to gain self-control. The cognitive-behavioral model can provide depression sufferers with cognitive and behavioral strategies that help them develop a sense of self-efficacy while learning to adjust to their disorder and overcome barriers to their acceptance of pharmacotherapy when necessary.

The Relevance of Culture in CBT Practice

The U.S. Department of Health and Human Services (2001) has stated that ethnic minorities in the United States are less likely to receive appropriate mental health treatment when they seek services. The practice of psychotherapy is dominated by the cultural values, assumptions, and perspectives that belong to an Anglo majority society; these differ from those in ethnic minority groups. The values and beliefs can be significantly different between cultures, because individuals who grow up in different cultures *think differently*. Knowing and understanding such differences is relevant for the way in which clinicians approach psychopathology and the treatment of psychological disorders. For instance, the psychotherapeutic emphasis on assertiveness, personal independence, change, and self-disclosure that apply to clients from Western cultures (e.g., White European Americans) may not be suitable to clients from Eastern cultures (e.g., Asians), who embrace different cultural values, such as acceptance, interdependence, and protection of the family's "good name." Several studies (Ji, Nisbett, & Sue, 2001; Masuda & Nisbett, 2001; Norenzayan & Nisbett, 2000) have found

that individuals from Western cultures tend to be more analytic in their thinking and seek to solve contradictions, whereas Asians are more holistic in their thinking, pay more attention to the context and relationship of objects, rely on experienced-based knowledge, and are more tolerant of contradictions. It is then reasonable to affirm that these differences in reasoning, beliefs, and values across cultures have unique implications for psychological treatments.

CBT is one of the most extensively researched forms of psychotherapy and has repeatedly demonstrated its effectiveness in the treatment of different, enduring mental health disorders (e.g., depression) on outpatient research settings. However, few studies have explored the generalization of this treatment approach in less standardized open-ended treatment conditions with clients in ethnic minority groups. Despite psychologists' acknowledgement of multicultural issues and the impact of such issues in treatment, CBT research has primarily focused on white, middle-class, well educated clients, who are of European American identities (Hays, 1995; Iwamasa & Smith, 1996; Organista, Munoz, & Gonzalez, 1994; Suinn, 2003). The literature suggests that the neglect of ethnic and cultural information in clinical and counseling research prevails across psychotherapeutic models, including CBT. Although there is a large population of ethnic minorities in the USA, few CBT interventions have been tested with ethnic minority groups (Chen, Kramer, Chen, & Chung, 2005; Nagayama Hall, 2001). In most treatment studies, ethnic minorities are underrepresented when compared with White European American samples and when ethnic minority individuals are included in these studies, results do not include ethnicity data (Wearing & Weisz, 2002). This omission may be influenced by the cultural homogeneity in the psychology field, as indicated by the fact that 85% of

psychologists and 94% of American Psychological Association (APA) members are of European American origin (APA, 2005; Dittman, 2003). The field is yet to generate studies on CBT outcomes that target clients from ethnic minority groups.

Fortunately, there is now an enormous interest among clinicians to understand diversity and to develop more suitable treatment interventions that attend to the cultural uniqueness of clients in ethnic minority groups. A report from the Surgeon General on mental health in the United States has highlighted the great need for culturally competent services, addressing both the uniqueness of the individual and the influences associated with his/her culture (U.S. Department of Health and Human Services, 1999). Equally relevant are the guidelines published by the American Psychological Association (APA), emphasizing the importance of cross-cultural competence for therapists and researchers (APA, 2002). In that effort, a growing body of research (Dana, 2000; Pope-Davis & Coleman, 1997; Sue, 2001; Sue 2003, Sue & Sue, 2003) has demonstrated that cross-cultural competence improves assessments and facilitates therapy interventions. Many suggestions have been advanced (Hays, 1995; Hays & Iwamasa, 2006; Organista, 1996, 2000, 2006) on how to make CBT culturally sensitive and on how to adapt this treatment model to ethnic minority clients such as Hispanics/Latinos by emphasizing the advantages and limitations of the treatment model to the uniqueness of the group. However, despite the growth in multicultural research, and the consensus that CBT principles must be modified to the particular culture in order to be compatible with the specific style of reasoning and thinking, there are few studies (Rosello & Bernal, 1999; Rosello & Bernal, 1996; Interian & Diaz-Martinez, 2007) that demonstrate incorporation and implementation of the suggested multicultural adaptation of CBT interventions with

Hispanics/Latinos. From a culturally specific perspective, researchers (Ritscher, Struening, Hellman, & Guardino, 2002) argue that current diagnostic criteria require changes to meet ethnic minorities' needs, acknowledge the discrepancies in the quality of psychotherapy services delivered to Whites and to ethnic minorities in the USA (Voss Horrell, 2008), emphasizing the need to modify empirically supported treatments such as CBT to increase treatment effectiveness among ethnic minorities (Dowd, 2003; Miranda, 1996; Nagayama Hall, 2001), and to advocate for cultural modifications in CBT interventions (Hays, 1995; Hays & Iwamasa, 2006; Interian & Diaz-Martinez, 2007; Organista, 1996, 2000, 2006). However, the literature does not show comparative studies between culturally modified interventions and non-modified interventions (Voss Horrell, 2008).

The Effectiveness of CBT with Ethnic Minority Groups

In a recent study, Voss Horrell (2008) found 12 studies that evaluated the effectiveness of cognitive-behavioral interventions with adults from African-American, Asian American, or Hispanic/Latino ethnic minority groups. Those studies examined the effectiveness of CBT in the treatment of depression, post-traumatic stress disorder (PTSD), panic disorder with agoraphobia, and substance abuse among ethnic minority individuals. Six of the 12 studies reported findings on CBT interventions for ethnic minority adults with depression (Voss Horrell, 2008). Three studies (Lara and colleagues, 2003; Miranda et al., 2003, 2006; Revicki et al., 2005) have reported promising results for the application of CBT with Hispanic/Latino women. These studies affirm that CBT is an effective treatment approach to reduce depressive symptomatology in low-income Hispanic/Latino women. Treatment gains as a result of CBT groups and

pharmacotherapy interventions were maintained after 12-month follow-up (Revicki et al., 2005) and participants who completed a minimum of 6 weeks of CBT intervention did not meet diagnostic criteria for depression after 12-month follow-up (Miranda et al., 2006). CBT is an effective intervention for Hispanic/Latino women, but there is limited information on its effectiveness with Hispanic/Latino men (Voss Horrell, 2008).

Sue and Sue (2003) emphasized the fact that many interdependent variables influence the effectiveness of psychotherapeutic interventions with ethnic minorities (e.g., immigration history, minority status, degree of assimilation, socioeconomic status, level of education, access to health care), which add complexity to the identification of factors that impact treatment outcomes. These authors recommend that clinicians conduct therapy in the client's native language, and address matters of cultural differences at the beginning of treatment.

Why is CBT the Best Approach for Hispanic/Latino Clients?

The National Institute of Mental Health (2003) has identified CBT to be among the most effective treatment approach for depression, and many studies have demonstrated that CBT has provided favorable results in the treatment of Hispanic/Latino clients with depression (Miranda, Azocar, Organista, Dwyer, & Areane, 2003; Miranda, Chung, et al., 2003). Moreover, group CBT is considered a viable intervention for these clients. CBT methods are congruent with those short-term goals that Hispanic/Latino clients seek in treatment, which include immediate symptom relief, time-limited services, directive intervention (guidance and advice), and problem-solving (Organista, 2000). The didactic approach of CBT offers Hispanic/Latino clients the opportunity to learn about their mental health disorders in a manner that is neither threatening nor challenging

to them, but is educational. The emphasis made in the literature about tailoring CBT interventions to Hispanic/Latino clients' unique cultural beliefs, gives these clients the opportunity to acquire self-change skills while giving attention to their specific behaviors (Hays, 1995). The implementation of *dichos* in CBT with Hispanics/Latinos offers a great opportunity to facilitate cognitive restructuring within a culturally sensitive treatment frame. Furthermore, CBT action approach (behavior change) can teach Hispanic/Latino clients to manage environmental factors that cause their emotional distress.

In sum, culture is highly relevant because it shapes individuals' perceptions and reasoning in profound ways. To improve recruitment and retention of ethnic minorities in research and to improve treatment outcomes, psychologists must acquire culturally competent skills (Pope & Davis, 2005). The CBT field has much to gain from culturally-sensitive trials that illustrate how CBT strategies work and do not work with minority populations such as Hispanics/Latinos. By implementing culturally tailored therapeutic interventions, psychologists can generate creative approaches that challenge, expand, and refine the CBT model to better serve a wider range of individuals. Studies beyond the report of ethnic composition of the samples are needed to develop mental health services that are more accessible and relevant to the lives of low-income and ethnic minorities (e.g., Hispanics/Latinos), who are an increasingly large portion of the population in the United States.

Making CBT Culturally Sensitive to Hispanics/Latinos

In recent years, there is marked interest among scholars to adapt empirically supported treatment methods, making them culturally sensitive to minority groups.

Researchers (Interian & Diaz-Martinez, 2007; Miranda & Munoz, 1994; Organista, 2000, 2006) advocate for culturally sensitive, time-limited Cognitive-Behavioral Therapy (CBT) for Hispanics/Latinos patients diagnosed with depression, particularly for those struggling with immigration, acculturation, and cultural adaptation. They have proposed specific adaptations of CBT to fit Hispanic/Latino culture.

Pumariega (2007), Santiago-Rivera (2003), and Santiago-Rivera, Arredondo, and Gallardo-Cooper (2002) have identified cultural values and beliefs that are unique to Hispanic/Latino clients and are relevant to treatment adherence, effectiveness of treatment, and for making CBT culturally sensitive. These scholars emphasize that, when developing and implementing treatment interventions for Hispanics/Latinos, psychologists consider the educational levels, English language skills, income levels, and cultural values unique to these clients. They must also understand and respect their Hispanic/Latino clients' cultural beliefs (e.g., religious beliefs) and stigma about their mental illnesses or psychological problems. For instance, many Hispanics/Latinos believe that God will help them to overcome depression and these beliefs will influence how they respond to treatment interventions (Cabassa, 2007). Pumariega (2007) advised that mental health providers learn to bridge Hispanics/Latinos' cultural beliefs (e.g., religion, spirituality, familismo) with traditional Western treatment approaches. This suggests that some clients may respond better to the combination of mental health services and consultation with a traditional healer. Pumariega also proposed that these combined interventions should not contradict each other but work together to meet the clients' needs effectively. Given the collective nature of Hispanics/Latinos, social networks will influence how they cope with distress by facilitating or interfering with the

use of mental health treatment (Pescosolido et al., 1998). Because they tend to make their treatment decision based on what their families approve or disapprove, the participation of family members (e.g., parents, grandparents, uncles, aunts) in their loved one's treatment may be necessary to reduce stigma and promote treatment adherence (Pumariega, 2007; Santiago-Rivera, 2003; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002). For instance, nonblood relatives, such as godparents or co-parents (*padrinos* and *madrinas*, or *comadre* and *compadre*) are also considered important family members who may become involved in the client's treatment. Moreover, psychologists must keep in mind that these clients tend to be guarded and resistant to disclose personal or family issues if seeking professional help. Hispanics/Latinos tend to be protectors of their "family honor." A proverb (*dicho*) that reflects this practice states: "*La ropa sucia se lava en casa*" (The dirty cloth is washed at home).

Adapting and implementing CBT interventions for Hispanic/Latino clients, require that psychologists apply strategies that capitalize the cultural strengths of the Hispanic/Latino community. Rejecting or invalidating Hispanics/Latinos' cultural beliefs may lead to clients' treatment needs becoming unmet, increasing the risk for drop out from treatment. Santiago-Rivera (2003) affirmed that the particular ways in which Latinos/Hispanics cope with problems is determined by their cultural frames of reference. Thus, it is important to consider their unique life experiences without rushing into pathological interpretations. For instance, the loyalty and interdependence of family members may not necessarily be indicative of pathological enmeshment; therefore, other factors need to be considered when assessing the family's problems. Arredondo (2005)

emphasized that culture influences an individual's thinking and behavior, and clinicians must give consideration to their clients' ancestral roots and related historical events. Many researchers and scholars (Interian & Diaz-Martinez, 2007; Organista, 2000; Organista, 2006; Santiago-Rivera, 2003; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002) have noted that treatment approaches that are compatible with Hispanic/Latino cultural values, beliefs, attitudes, and experiences need to be flexible and creative by taking into account clients' acculturation levels, gender role expectations, health and illness beliefs, and life experiences in the U.S.

The following considerations have been proposed by those researchers who advocate for making therapeutic methods responsive to the uniqueness of Hispanics/Latinos' cultural values and beliefs.

1. Psychologists and mental health providers, in general, must be prepared to advocate for their Hispanic/Latino clients by playing different roles and coordinating services beyond the therapy services (Bean et al., 2001; Interian and Diaz-Martinez, 2007; Organista, 2006; Organista & Munoz, 1996; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002).
2. Efforts should be made to facilitate client-counselor match by ethnicity, culture, race, and language. A client-therapist match helps strengthen the therapeutic alliance, reduce attrition, maximize treatment adherence, and enhance identity development and modeling (Martinez, 2000; Sue & Sue, 1999). Interian & Diaz-Martinez (2007) noted that by providing language compatibility with the CBT therapist, as well as with the other staff with whom Hispanics/Latinos interact in treatment maximizes their access to

treatment and their retention in psychotherapy. Ethnically different therapists must acquire cultural knowledge that relates to their minority clients.

3. It is important to assess clients' proficiency in the English language to rule-out the need for an interpreter. In ideal treatment circumstances, the mental health provider should speak Spanish. When interpretation services are required, the interpreter must be knowledgeable in psychological processes (Bean, Perry, & Bedell, 2001). The children in the family should not be given the role of interpreters because such a role empowers them over their parents, diminishing the parents' authority.
4. Based on their studies and clinical experiences with depressed Hispanics/Latinos, Interian & Martinez-Diaz (2007) advocate for the implementation of *ethnocultural assessment* (e.g., ethnic heritage, country of origin, reasons for emigrating, method used to arrive in the U.S., effects of the migration, reaction of family members, change in social and occupational status), which should take place at the beginning of therapy with the purpose of understanding the specific cultural factors of individual clients and formulate more accurate statements that are reflective of the client's specific cultural background. Santiago-Rivera et al. (2002) described a similar approach which they call the Culture-Centered Clinical Interview (CCCI). The focus of the CCCI is giving high consideration to the client's cultural background in the assessment process.
5. Interian and Diaz-Martinez (2007); Santiago-Rivera et al. (2002) noted that acculturation impacts recent immigrants as well as those who have lived in the

U.S. for generations. Hence, assessing the clients' levels of acculturation helps determine to what extent their emotional distress relates to acculturation.

Psychologists must allow Hispanic/Latino clients to tell their immigration journey, including their experiences of grief and loss as well as their sense of cultural adaptation. They must also determine and show respect for the clients' health and illness beliefs, their use of folk healers, and whether or not they seek help from extended family members during times of distress.

6. Maintaining a flexible time is necessary when working with Hispanics/Latinos because punctuality is not a standard practice among them (Santiago-Rivera, 2003; Santiago-Rivera et al., 2002). Interian & Diaz-Martinez (2007) recommended flexibility with regard to tardiness and to rescheduling appointments, telephone calls to confirm the appointments, and follow-up calls when clients do not keep appointments. Moreover, male Hispanic/Latino clients may not keep appointment times during work hours, because these may interfere with their roles as providers for the family. Therefore, after-work appointment times should be offered to such clients. These are strategies that contribute to treatment access, treatment retention, and provide a form of personal interaction, *personalismo*. Organista (2000) recommended a "role preparation" for decreasing drop-outs. Clients are invited to a pretreatment orientation session that gives them the opportunity to meet bilingual, bicultural Hispanic/Latino staff and therapists. In this session, clients are provided with drinks and snacks while learning about the structure and process of therapy.

7. It is important to demonstrate *simpatia* and *personalismo* when interacting with Hispanic/Latino clients in order to gain their *confianza* (trust). In order to achieve *simpatia*, Santiago-Rivera et al. (2002) suggested engaging clients by approaching them in a friendly, warm, and genuinely concerned manner. They must also be addressed with *respeto* (respect). Interian & Diaz-Martinez (2007) indicated that to practice *simpatia*, psychologists must express warmth and kindness in an obvious and expressive manner, with emphasis on positive aspects of interaction and avoiding confrontational approaches. Martinez & Guarnaccia (2007) noted that neutral and passive dispositions on the part of the therapist may be perceived as coldness by Hispanic/Latino clients, and, consequently, become a barrier to treatment and to the development of rapport. Interian & Diaz-Martinez (2007) proposed that therapists express *simpatia* even when setting limits in treatment. For instance, when clients are late for appointments, therapist must express concern for their delay, emphasize appreciation for their efforts and gladness for their attendance. With regard to *personalismo*, Organista (2000); Santiago-Rivera et al. (2002) noted that Hispanic/Latino clients may perceive direct communication styles rude, insensitive, or impersonal. Therefore, sensitive issues need to be presented to these clients with a clear recognition that the message may be interpreted as intrusive or offensive. Santiago-Rivera and colleagues recommend statements such as, “Please excuse me but I need to address an issue that may be difficult...” or “With all due respect, I need to let you know...” Organista (2000) advocates for incorporating the value of

personalismo by making small talk or *platica*, with prudent self-disclosure, in order to find balance between task-oriented formality and *personalismo* (personalized attention to the client). According to Organista (2000), the first session should allow time for *presentaciones* (introductions) by which therapist and client share personal background information (e.g., where are they from, their families, types of work, personal interests). Therapist and client get to know each other a little before dealing with the problems that brought the client to treatment. Interian and Diaz-Martinez (2007) suggested that therapists can demonstrate *personalismo* toward their Hispanic/Latino clients by personally calling them on the phone to schedule, confirm, or reschedule appointments. They are also advised to remember the names of their clients' children and family members and ask for them in the course of treatment. The challenge is to maintain a balance between *personalismo* and *formalismo*.

8. **Formalismo** and **respeto** can be achieved by acknowledging the clients' hierarchical roles (e.g., older adults, parents, husbands in cases of traditional gender roles), addressing clients as *Senor* (Mr., male) or *Senora* (Mrs., female) followed by their last names, and using the formal word for you, *usted* (Interian & Diaz-Martinez, 2007; Santiago-Rivera et al.).
9. **Familismo**, a highly regarded value among Hispanics/Latinos, requires recognition of clients' strong reliance on the family and the importance of meeting the family's needs above that of the individual. Interian and Diaz-Martinez (2007) argued that *familismo* is likely to influence the client's

motivation and behavior. It may be a potential barrier to treatment when the client's motivation and behavior are opposed to those of the family, or it can be a source of motivation when used to promote behavioral change. Santiago-Rivera (2003); Santiago-Rivera et al. (2002) recommended using *familismo* as strengths within the families.

10. ***Faith*** and ***religious beliefs*** that influence Hispanics/Latinos' *acceptance* of unfortunate events may represent a challenge to CBT interventions, which focuses on modifying clients' cognitions, mood, and behaviors, (Interian & Martinez-Diaz, 2007). Psychologists need to develop and implement treatment interventions that include religious coping when working with these clients, such as using cognitive or behavioral strategies that are based on religious beliefs or practices (e.g., praying, seeking comfort from God, and the using *dichos*). Organista (2000) suggested reinforcing church attendance and prayer as behavioral and cognitive strategies to help clients with traditional religious beliefs to cope with stress and negative mood states. However, he challenges those forms of prayer that do not elicit active problem-solving (e.g., "just prayed") by shifting prayer into a more active direction. Organista's technique is that of discussing *dichos* (*proverbs*), such as "*Ayudate, que Dios te ayudara*" (God helps those who help themselves), or "*Dios dijo, ayudate que yo te ayudare*" (God said, help yourself and I will help you). The emphasis on such *dichos* seeks to motivate clients to modify their prayers and start asking God for strength and support to try new behaviors (e.g., daily activities, assertiveness).

11. *Dichos* or *refranes* (proverbs) can be used to educate Hispanic/Latino clients on CBT principles by framing the language of the theory in a manner that is compatible with the Hispanic/Latino culture. Interian and Diaz-Martinez (2007) noted that *dichos* should complement the communication of therapeutic concepts but not replace it. In this sense, to explain the relevance of behavioral activity vs. inactivity, the therapist may state: “*Camaron que se duerme se lo lleva la corriente*” (The shrimp that falls asleep is taken by the tide). A *dicho* that may elicit discussion on avoidance is that of “*Ojos que no ve, corazon que no siente*” (Eyes that do not see, a heart that does not feel). Non-Hispanic/Latino therapists must seek consult with Hispanic/Latino colleagues before implementing *dichos* (proverbs), because their effective application in therapy requires mastering the Spanish language. Moreover, the client’s level of acculturation will determine how much effect the *dicho* will have (Interian and Diaz-Martinez, 2007). Less highly acculturated Hispanics/Latinos tend to use more *dichos* than those with higher level of acculturation.
12. In order to facilitate *desahogo* (getting things off one’s chest, or unburdening oneself) therapists must be receptive and give time for their Hispanic/Latino clients to describe events or thoughts using a lot of details, which is a traditional characteristic among these individuals. Therapists should be aware that some Hispanics/Latinos may speak louder and may be more expressive with their hands when talking (Santiago-Rivera et al., 2002). Interian and Diaz-Martinez (2007) noted that *desahogo* may be inhibited by CBT directive

techniques and psychoeducational approaches and recommend that strategies such as thought or activity records be used to facilitate *desahogo*.

Teaching CBT Skills to Hispanic/Latino Clients

The therapeutic task of teaching Hispanic/Latino clients to associate their distress with maladaptive cognitions may be a challenge, because of their promptness to attribute their distress to difficult life situations rather than to their thoughts. The following recommendations have been proposed by scholars whose work focus on Hispanic/Latino clients.

1. Organista (2000, 2006); Organista and Munoz (1996) suggested challenging cognitive distortions and teaching cognitive restructuring by using the technique “*Si, pero...*” (Yes, but...), with the purpose of prompting clients to defeat cognitive distortions associated with depression or anxiety. This technique teaches Hispanic/Latino clients to consider less negative alternatives associated with their distress. Organista (2000) noted that the “*Si, pero...*” technique teaches clients that much of their problematic thinking is due to “half-truths,” which they need to change into “whole-truths.” He also recommended teaching Hispanic/ Latino clients to differentiate between “helpful” thoughts that help reduce symptoms and initiate adaptive behaviors, and “unhelpful” thoughts that do the contrary. Organista (2000) provides an example of his technique in the case of Hispanic/Latino clients whose sense of self-worth depends on their ability to provide for their families. As a result, these clients think “*No sirvo para nada*” (I am good for nothing). Cognitive restructuring is elicited by asking these clients to complete a statement like

“Yes, my health problems do limit what I can do, but...” to which clients often respond with statements such as, “but, that doesn’t mean I am worthless;” “there are still some things I can do for my family.” Organista avoids labeling clients’ thoughts as irrational or distorted. Instead, he seeks to express to clients that their thoughts are understandable in light of their particular life circumstances.

2. Understanding cognitive distortions may be even more difficult for those Hispanic/Latino clients with limited educational backgrounds (Interian and Diaz-Martinez, 2007). Munoz et al. (2000) implemented the technique called *chaining*, by which the identification of a cognition that is a response to an event leads clients and therapist to generate other alternative cognitions for the same event. This technique help clients recognize the variation in adaptiveness generated in their responses. Eventually, clients learn to control their cognitions by predicting and eliciting more adaptive thoughts that cause less distress and preventing more negative thoughts that cause greater distress. *Chaining* can also be applied when teaching clients behavioral techniques.
3. Teaching clients to modify cognitions associated with religious beliefs (e.g., acceptance of one’s fate) is another potential difficulty that requires special attention and effort when explaining cognitive restructuring to Hispanic/Latino clients. Organista (2000) addressed serious cases in which clients refuse to take medication for severe medical problems and place their fate in the hands of God. These clients usually state: “*Que sea la voluntad de Dios*” (Let it be God’s will); “*Si es la voluntad de Dios que yo muera, asi*

sera” (If it is God’s will that I die, he would do so). Organista proposes telling these clients that they are “testing” God’s will, and to question “Who are we to do so?” Moreover, Organista suggests to his clients, that if they want to test God’s will, they first must use all the resources that God has provided them with and then see what happens.

4. The use of *dichos* can help Hispanic/Latino clients acquire CBT skills. Interian and Diaz-Martinez (2007) suggested that teaching clients to challenge cognitive distortions and cognitive restructuring may be facilitated with *dichos*, such as “*Todo es segun el color del cristal con que se mira*” (Everything is according to the color of the glass with which is viewed) and “*Dios aprieta pero no ahoga*” (God squeezes, but does not choke). The latter is a *dicho* that can help clients recognize the fact that despite experiencing continuous stressors, they manage to overcome their difficulties. Behavioral techniques (e.g., behavior can improve mood) can be taught by eliciting *dichos*, such as “*Camaron que se duerme se lo lleva la corriente*” (The shrimp that falls asleep is taken by the tide). Organista (2000) suggested using the statement “*Al que madruga Dios lo ayuda*” (God helps the early riser) when working with clients who live by religious/spiritual faith. Other researchers (Interian & Diaz-Martinez, 2007; Martinez & Guarnaccia, 2007) found that “*Poner de su parte*” (Doing your/their part) was a *dicho* that could be effectively invoked when framing the rationale for implementing behavioral techniques. In this sense, Hispanic/Latino clients are given the chance to *Poner de su parte* in improving their mood and functioning.

5. When teaching assertiveness to Hispanic/Latino clients it is necessary to identify first the acceptability of assertive behavior in the clients' social and family environment. Assertive communication may be contrary to the Hispanics/Latinos' emphasis on communication that is polite, non-confrontational, and deferential. Promoting assertiveness without cultural considerations can also conflict with the clients' traditional values of *familismo*, *respeto*, and *Marianismo*. Organista (2000) suggested the following statement to address culturally compatible aspects of assertiveness (e.g., *respeto*, *familismo*): “*Con todo respeto, me permite expresar mis sentimientos?*” (With all due respect, would you permit me express my feelings?); “Would you permit me to say something about that?” “If you do not let me to express my feelings to you, I’m going to feel bad and resentful toward you; I really don’t want to do that;” “Expressing my feelings makes me less upset and better able to handle things.” Organista (2000) also recommended asking Hispanic/Latino clients what happen when they *guardan* (keep) their negative feelings inside. This approach usually elicits acknowledgement of increased physical illness or somatic symptoms, which motivates clients to become assertive in order to prevent serious illness. Applying the value of *familismo* as a rationale to implement behavioral strategies (e.g., pleasurable activity, taking time for oneself) is another strategy to teach assertiveness without disregarding Hispanics/Latinos' cultural emphasis of putting the needs of family members above one's own

needs. In this sense, clients need to be persuaded that doing the recommended strategy will improve their moods and enhance family relationships.

6. Relaxation techniques, deep breathing exercise, physical exercise, and distractions are recommended strategies that can help depressed Hispanic/Latino clients reduce autonomic arousal and cope with problems of *ataque de nervios* (nerves' attack), which tend to manifest with emotional and physical symptomatology (Guarnaccia, Lewis-Fernandez, & Rivera Marano, 2003).

Overall, there are great similarities among depressed clients because such a mental disorder affects individuals across racial, ethnic, and socioeconomic backgrounds. All of them experience significant suffering and loss of productivity as a result of depression. All clients diagnosed with depression need understanding, patience, and support. CBT helps promote a sense of caring that is important in any culture. However, the adaptation of CBT methods specifically designed to serve Hispanic/Latino clients by addressing their cultural uniqueness is not only relevant to enhancing their access to mental health services and their treatment retention, but it is also essential for the promotion of their mental health.

CHAPTER III

Method

Data Sources and Collection

Research Design

Qualitative research is the type of study that leads to findings not arrived at by statistical procedures or other means of quantification. It applies a nonmathematical process of data interpretation with the purpose of discovering concepts and relationships in the data, and organizing them into a theoretical explanatory scheme (Straus & Corbin, 1998). Qualitative studies seek to understand the meaning or the nature of persons' experiences by getting out into the field and finding out what people are doing or thinking. It is all about exploring issues, understanding phenomena, and answering questions. Qualitative methods are used to gather the intricate details about phenomena such as human experience, feelings, thought processes, subjective views, reactions, and emotions that are difficult to obtain or learn about through conventional research methods (Kazdin, 2003; Straus & Corbin, 1998). This is achieved by seeking out the "why," not the "how" of the topic and analyzing unstructured information/data (e.g., written interviews, interviews transcripts, recordings, notes, feedback forms, questionnaires, photos, videos, and so on). Because qualitative research begins with an area of study and allows the theory to emerge from the data, the theory derived is more likely to resemble the "reality," offer insight, enhance understanding, and provide a meaningful guide to action. Focus groups, in-depth interviews, and content analysis are some of the many format approaches that are used by qualitative researchers.

The research study described herein illustrates a qualitative approach that seeks to investigate and describe the implementation of traditional Hispanic/Latino cultural values when providing Cognitive-Behavioral Therapy in a group setting. In the study, the qualitative method utilizes a grounded theory strategy of open-ended questions as an analytic device to elicit a line of inquiry that will lead to data collection and the researcher's interpretation of the data, derived from views of the participants (Creswell, 2009).

Participants

Purposeful sampling was implemented in this study to recruit 10 bilingual mental health providers (Spanish-English/English-Spanish) in different regions of the country. They were identified through mental health directories and contact with colleagues. Eight mental health providers agreed to participate in the study. Two of those participants withdrew early in the demographic information collection phase, because of career change and relocation. Demographic information was collected from 6 participants; however, only 4 of them completed the study. Specifically, the fifth and sixth participants were not able to provide their comments (data) for analysis within the time frame required to complete this study.

The final sample consisted of 4 participants (all women). One participant held a Doctorate of Philosophy degree and three participants held Master's degrees. Participants ranged in age from 30 to 59 years. Three of four participants identified themselves as Caucasian/White and one participant identified herself as "other" (more than one race). Two of the participants were born in Peru, and two were born in the United States. However, one of the two participants born in U.S. identified Mexico as

her country of origin. Regarding Ethnicity, three of the participants were Hispanic/Latino and one participant was neither Hispanic nor Latino. One of the three Hispanic/Latino participants noted both Hispanic/Latina as self-identification, whereas the remaining two Hispanic/Latino participants self-identified as Latinas. Regarding language, three of the four participants' first language was Spanish and the remaining participant's first language was English. All four participants were bilingual (Spanish/English-English/Spanish) and were fluent in both languages. All four participants provided mental health services to clients in both languages (based on their clients' preferences). Two participants noted Spanish as their language of personal preference, and two participants noted both Spanish and English as their language preferences. Two participants lived and worked in the Western Region (Idaho); one lived and worked in the South-West Region (New Mexico), and one lived and worked in the Mid-Atlantic Region (Pennsylvania). Two of the participants practiced in urban areas; one participant practiced in a rural area, and one participant practiced in both rural and suburban areas.

Regarding therapeutic orientation, one of the participants noted cognitive-behavioral orientation, and the three remaining participants noted existential orientation, in addition to eclectic orientations, humanistic, and psychodynamic orientations, respectively. Participants' experiences as therapists ranged from 2 to 25 years. Their experiences in working with Hispanic/Latino clients ranged from 15 to 25 years. In regard to the average number of Hispanic/Latino clients the participants saw on a monthly basis, one participant reported 50 clients (women and men); one reported 15 clients (women and men); one participant reported 10 clients (women), and one participant reported 5 clients (women and men). Two of four participants provided

mental health services both to children and to adult clients (ages 5- 45), and the remaining two participants provided mental health services to adult clients (ages 20-50, and 20-70, respectively). Participants reported that their clients' average time in treatment ranged from 3 to 18 months. All participants provided services to clients from Mexico. However, one of the four participants also provided services to clients from Cuba, Puerto Rico, Dominican Republic, and Peru. Regarding the nature of their clients' mental health problems, all participants noted Depression as one of the reasons for treatment intervention. Three of the participants also noted anger management, anxiety, adjustment disorder, and acculturation. Two of the participants noted PTSD and marital/family problems. One of the four participants noted alcohol and substance abuse as another reason for treatment intervention. All participants based their levels of multicultural competence on personal experiences (e.g., immigration, born and raised in South America, raised in bilingual and bicultural environment, community exposure and involvement) and professional experiences (e.g., working with Hispanic/Latino clients). Two of the participants also noted formal training (e.g., graduate school and Continuing Education Units) as contributors to their levels of multicultural competence. No financial incentive was given to the participants and their names are not identified in the study.

Instrument Adapted

Treatment manual. This study examined the manual “*Guia para Miembros del Grupo*” (Group Members' Guidebook), authored by Jeanne Miranda and colleagues (2006). Dr. Miranda gave written approval for the use of her manual for dissertation and research purposes. The manual is written in Spanish in order to provide Cognitive Behavioral-Therapy (CBT) to Spanish speaking clients with depression. The manual

does not provide treatment guidelines that are culturally relevant to Hispanic/Latino clients. Miranda's treatment model also has a Group Leader's Guidebook written in English, which is similar to the Group Members' Guidebook, except that it includes instructions to help in presenting the CBT material. The present study concentrates on the Members' Guidebook (*"Guia para Miembros del Grupo"*). The study does not try altering or re-writing Miranda's manual. It provides recommendations to enhance the manual in a manner that Hispanics/Latinos' cultural values are addressed when implementing group CBT.

Treatment framework. Miranda's manual addresses thoughts, activities, and mood associated with group members' depression. It is organized in 12 session modules (3 modules with 4 sessions each). This study focuses on the First Module, "Thoughts and Your Mood," which includes sessions 1 thru 4. The first module addresses the connection between thoughts and mood (Session 1); identification of harmful thoughts and helpful thoughts (Session 2); learning to challenge harmful thoughts (Session 3); and learning to develop more helpful thoughts to improve mood (Session 4). By focusing on the adaptation of the first module of the manual, this study provides a work example that may guide further research efforts to complete the cultural adaptation of the manual. The manual second module, "Activities and Your Mood," and third module, "People Interactions and Your Mood," are material for further research.

Measure

Demographic data sheet. Participants' demographic information was gathered for general identification purpose. Data on 26 items were obtained, including basic demographics, educational background, professional background (e.g., with

Hispanic/Latino clients), languages proficiency, and level of multicultural competence (Appendix A).

Semi-structured interview. Semi-structured, open-ended questions in a written interview format were selected as the method of inquiry. Seven open-ended questions were developed for the study (Appendix B) to elicit participants' comments on the relevance of the recommendations provided by the researcher for cultural adaptation of the CBT manual. Participants were also asked to provide additional feedback they believed to be relevant.

Procedure

Participants (bilingual mental health providers) were recruited from professional settings (e.g., community mental health clinics, outpatient centers) known by the researcher or suggested by colleagues. The researcher approached participants via telephone and electronic mail to provide a brief explanation of the study and to invite them to participate. Contact information was provided for them to confirm their volunteer participation, ask questions, and/or gather more information about the study. Those who agreed to participate in the study selected electronic mail as the preferred way to communicate with the researcher. Participants were asked to complete the demographic sheet (Appendix A) via electronic mail. Each enrolled participant was provided with a manuscript with the researcher's written recommendations and instructions for their review and comments (Appendixes C1 thru C4). Participants had 1 month to complete their reviews; however, three of the four participants took 2 months to complete their reviews and needed two reminders via electronic mail. One participant completed her review in one week.

Participants provided their comments by answering specific, open-ended questions for each of the 4 Sessions. The following research questions were developed to investigate whether or not the researcher's recommendations addressed Hispanic/Latino clients' cultural values and beliefs.

1. With regard to the instructions provided for Session # ____:
 - a. Do you think the instructions provided for the Group Leader (therapist) are sufficient? Please explain.
 - b. Do you think the instructions provided for Group Members (clients) are sufficient? Please explain.
2. Do you think the questions provided to Group Members (clients) are sufficient? Please explain.
3. In the vignette about Fernando, did I address cultural values/beliefs relevant to Hispanics/Latinos? Please specify:
 - a. What was more helpful?
 - b. What was less helpful?
4. What cultural values and/or beliefs you feel that needed to be addressed in the session, but were not addressed?
5. Overall, in a scale from 0 (none) to 10 (most) please rate to what degree my suggestions addressed Hispanics/Latinos' cultural values and beliefs?
6. Is there any further recommendation you would add to make the treatment experience more culturally sensitive to Hispanic/Latino clients?
7. Is there any other comment you wish to add?

The information that participants provided was confidential. All participants seemed interested in contributing to the literature, relative to making treatment interventions culturally sensitive to Hispanic/Latino clients. The researcher transcribed all the interviews, which led to relevant process and content notes. The researcher read each of

the participants' answers several times to extract and summarize the information they provided.

Adaptation of treatment manual.

Recommendations were organized in 4 sessions (Module I, Sessions 1 thru 4) and elaborated as Appendix for each treatment session (Appendices C1 thru C4). The selection of Module I ("Thoughts and Your Mood") is relevant to the need of exploring the differences in reasoning, beliefs, and values that have unique implications for psychological treatments. Recommendations for the cultural adaptation of the indicated module addressed matters of cultural differences in treatment (Sue & Sue, 2003) by applying CBT principles that identify Hispanics/Latinos' unique thinking and influences associated with their culture (USDHHS, 1999). The recommendations employed a vignette approach with instructions both to the group leader (therapist) and to group members (clients). One vignette that was centered on a male character was developed (Appendix D), making it compatible to Hispanics/Latinos' cultural values and beliefs, as described in the literature. A vignette that was centered on a male character was suggested for two main reasons: (1) to give attention to gender role expectations that are traditionally differentiated in the Hispanic/Latino culture, and (2) to give attention to concerns that Hispanic/Latino men are more reluctant than Hispanic/Latino women to seek mental health treatment (Addis & Mahalik, 2003; Gonzales, Alegria, & Prihoda, 2005; O'Brien, Hunt, & Hart, 2005). The vignette was presented in stages throughout the treatment sessions, to elicit application of CBT principles addressed in the sessions. The specific vignette was intended to facilitate Hispanic/Latino male clients' recognition of depression and their thoughts about the kinds of intervention a person with those

symptoms should receive. The vignette was designed to help these clients identify and understand situations that are relevant to their own symptoms of depression. Specific questions were suggested to ease clients' identification with the character and situations presented in the vignette, and to practice what they learned in the sessions. They are prompted to imagine having the same experiences described in the vignette, or they are asked whether or not they know someone who has lived through similar situations.

Vignette

Barter and Renold (1999) stated that vignettes facilitate actions in the context to be explored, help clarify people's judgments, and provide a less personal and therefore less threatening way of exploring sensitive topics. Vignettes provide opportunities to elicit respondents' imaginations, critical thinking, and reflections (Poulou, 2001).

Vignettes arouse respondents' interests, and facilitate assessments of their cultural norms by eliciting attitudes and beliefs towards the situation presented in the vignette (Barter & Renold, 1999).

CHAPTER IV

Results

Data Analysis and Interpretation Procedures

Participants' comments and feedback answers provided the data analyzed by the researcher conducting the qualitative research. The data obtained in the proposed study was gathered solely via the interview process through electronic mail. The Grounded Theory Approach to qualitative research was implemented to assess and analyze the data (Creswell, 2009). Data analysis in the present study implies identification of themes that arise through the communication between the researcher and the participant. All of the participants' feedback answers were transcribed for review and analysis by the researcher conducting the study. The researcher identified key themes that emerged from the participants' answers. The understanding and synthesis of the participants' comments required reflection time and immersion in the data (Boss et al., 1996).

Demographic Findings

The participants in this study were four bilingual mental health providers who ranged in age from 30 to 59 years. Participants had from two to twenty-five years of experience as therapists, and from 15 to 25 years of experience working with Hispanic/Latino clients. Three of the participants were Hispanic/Latino. Spanish was the first language of three of the participants. The remaining participant's first language was English. All participants were bilingual (Spanish/English-English/Spanish) and fluent in both languages. All participants provided mental health services to Hispanic/Latino clients in both languages (Spanish/English). All participants noted "Depression" as one of the mental health issues for which they provided care for their Hispanic/Latino clients.

All participants described their levels of multicultural competence associated with personal and professional experiences, and with formal training. Table 1 summarizes a breakdown of the participants, according to their levels of education, origins of birth, ethnicities, language ability, language of preference, years in practice, therapeutic orientations, and levels of multicultural competence.

Participant	Level of Education	Origin of Birth	Ethnicity	First Language	Language Ability	Language Preference	Years in Practice	Therapeutic Orientation	MCC (personal, professional , and training)
1	PHD Community Psychology	Peru	Hispanic/ Latino	Spanish	Fluent Spanish and English	Spanish	25	Eclectic and Existential	Born and raised in SA, exposure and involvement with H/L community in USA. Working with H/L clients in SA and USA. Graduate school in SA and USA, CEU.
2	MS Counseling	USA	Hispanic/ Latino	Spanish	Fluent Spanish and English	Spanish and English	2	Humanistic and Existential	Struggles as first generation individual. Working with H/L clients. Graduate school and CEU .
3	MA Applied Psychology	USA	Neither Hispanic/ Latino	English	Fluent English and Spanish	English and Spanish	15	Cognitive-Behavioral	Raised in bilingual and bicultural environment, exposure and involvement with H/L community. Working with H/L clients. Research work. Specialized training for bilingual MH providers
4	MS Clinical Psychology	Peru	Hispanic/ Latino	Spanish	Fluent Spanish and English	Spanish	23	Psychodynamic and Existential	Born and raised in SA. Working with H/L clients in SA and USA. Graduate school in SA.

Table 1. Demographics of each participant relative to level of education, origin of birth, ethnicity, language ability, language preference, years in practice, therapeutic orientation, and level of multicultural competence (MCC)

Note. SA = South America; USA = United States of America; H/L= Hispanic/Latino; MH = Mental Health; CEU = Continuing Education Unit

Descriptive Findings

The therapist is responsible for modeling the structure of the session without appearing “controlling” (Beck, 1995). The instructions on how to structure the session help the therapist prioritize what the focus of the session will be and the order in which the items relevant to the session are presented to the client. Instructions help therapist and client to set an agenda with a clear beginning, middle, and end to each session. Instructions to clients are aimed at setting an agenda that elicits their expectations for the therapy session and addresses issues that are significant to them. Although there are subgroups of Hispanics/Latinos that are quite different from one another, these individuals share elements of history, language, customs, religion and moral values, self-identity, and identity attributed by others (Organista 2006), which makes them unique. Knowing and understanding Hispanics/Latinos will help clinicians provide mental health care in a culturally sensitive manner. The following comments/recommendations were given by the participants in the present study regarding the researcher’s suggestions for making CBT interventions culturally sensitive to adult Hispanic/Latino clients with depression.

Session 1- “Your Thoughts and Mood are Connected.”

Question One: (a) Do you think the instructions provided for the Group Leader are sufficient? Please explain.

When the participants were asked to comment on whether or not the instructions provided for the Group Leader (therapist) in Session 1 were sufficient, all of them agreed that the instructions were “*clear, concise, simple, and provided a brief overview of the session.*” One of the participants stated, “*I appreciated the instructions along the way of*

reading too.” Another participant suggested including an instruction for the group leader to use a dry-erase board to facilitate discussion in the session. This is a valuable recommendation, because Group Members’ attention and participation throughout the therapy sessions may be enhanced by presenting the information both in auditory and in visual forms. The use of a dry-erase board may also facilitate the collaborative interaction between the group leader and group members, which is an essential component of CBT.

Question One: (b) Do you think the instructions provided for Group Members are sufficient? Please explain.

When asked if the instructions provided for Group Members (clients) in Session 1 were sufficient, all participants answered that the instructions were “*sufficient, formally simple, and understandable.*” One participant emphasized the importance of making the instructions clear and simple and eliminating multiple questions for a specific topic. Another participant suggested rewording the introduction of the vignette on Fernando by stating “*This is the beginning of his story*” instead of “*This is his story.*” This feasible recommendation would help emphasize the continuation of the vignette (Fernando’s story) throughout the sessions.

Question Two: Do you think the questions provided to Group Members are sufficient? Please explain.

All four participants in this study noted that the questions provided in Session 1 were sufficient for emphasizing treatment issues and for helping Group Members practice what they learned during the session. Participants stressed the importance of eliciting clients’ disclosure of their issues in a gradual and safe manner. One participant stated, “*The instructions concentrate on the vignette. It is a great process from general to*

particular, and to promote disclosure.” Another participant noted, *“Asking questions about the vignette first, may be safer than focusing on their issues.”* Other participant explained, *“The uses of the vignette and follow-up questions help reinforce the material presented in the module.”* One participant indicated, *“The instructions tell clients, in a simple, neat, and real way how to target their own experiences through Fernando’s story.”* Participants believed that the vignette on Fernando helps Group Members put the actions to be explored in context and provides a less personal and therefore less threatening way of exploring sensitive topics (Barter and Renold, 1999).

Question Three: In the vignette about Fernando, did I address cultural values/beliefs relevant to Hispanics/Latinos? Please specify. What was more helpful? What was less helpful?

When the participants in this study were asked if the vignette about Fernando in Session 1 addressed Hispanic/Latino cultural values/beliefs, three of the four participants in this study noted that the vignette on Fernando did address Hispanics/Latinos’ cultural values or beliefs. One participant added, *“Examples were connected and understandable, and the target group could make sense.”* Another participant recommended the following, *“To read the vignette in Spanish to concur with the module material [Miranda’s manual] in Spanish.”* This is a valuable recommendation, which the researcher had previously considered implementing when developing the proposal for this study. However, for dissertation purpose, the material (e.g., vignette) had to be submitted in English. The participant’s recommendation should be taken into account for further studies.

One participant differed in the view of the traditional roles (Machismo-Marianismo) as described in the vignette. This participant noted that the vignette addressed Hispanic/Latino cultural values “*Partially,*” and stated “*Although the cultural values addressed in the vignette apply for most of the Hispanic population, the ‘macho view’ ... implies low aspiration and prejudice towards the female.*” The participant’s comments suggest the relevance of developing a vignette centered in a female character for future research.

In discussing what was more helpful in the vignette about Fernando, the importance of family values and traditional roles’ expectations emerged in the participants’ responses. Family was an important aspect of the vignette for all of the participants in the study. They also endorsed the use of proverbs (“*dichos*”). Three of the participants found the story of Fernando’s journey to U.S. helpful in order to elicit group members’ immigration experience. A representational statement was “*It is good to break the ice with introductions and the sharing of their own personal story.*”

When asked what was less helpful in the vignette about Fernando, two of the participants noted the vignette was “*a little too long.*” One participant suggested, “*Shorten the story ... by not providing all the specifics.... so the Group Members can add their own personal details.*” One of the participants recommended “*Introduction of more concrete cultural details that can contribute to the depression, such as longing for typical meals, festivities, and favorite cultural programming.*” These suggestions are important and worth using in the future to help Group Members identify symptoms of depression associated with “homesick symptoms,” family loss, and missing traditions.

Question Four: What cultural values and/or beliefs you feel that needed to be addressed in the session, but were not addressed?

Three of the participants in the study did not feel there were other cultural values/beliefs that needed to be addressed in Session 1. One participant, who previously differed in the description of traditional roles expectations, noted that “*women have other social roles defined, besides that of housewife.*” The participant’s comment suggests a request for women to be portrayed in less traditional roles, which may be relevant in the context of generational differences and this aspect needs to be explored further.

Question Five: Overall, in a scale from 0 (none) to 10 (most) please rate to what degree my suggestions addressed Hispanics/Latinos’ cultural values and beliefs?

When asked to rate the degree to which the researcher’s suggestions addressed Hispanics/Latinos’ values in Session 1, two of the participants in the study rated the suggestions “9.” One participant rated the suggestions “8,” and another participant rated the suggestions “7.” The mean score for the participants’ overall rating was 8.

Question Six: Is there any further recommendation you would add to make the treatment experience more culturally sensitive to Hispanic/Latino clients?

When asked about additional recommendations that would make Session 1 more culturally sensitive to Hispanic/Latino clients, three participants in the study did not find the need to provide further suggestions. One participant emphasized the value of the vignette and proverbs used in the session. She stated, “*The introduction of the particular vignette and proverbs were very functional.*” The same participant added, “*soap opera, current news, and movies related to the theme could foster discussion.*” This recommendation identifies the value of using every day events to facilitate discussion and

to add flexibility to the therapeutic relationship when working with Hispanic/Latino clients.

Question Seven: Is there any other comment you wish to add?

No additional comments were provided by the participants. One participant stressed the value of the cultural component included in the session. She noted, “*Adding the cultural component made it easier for me, as Latina, to relate.*”

Session 2 – “Identifying Harmful Thoughts and Helpful Thoughts”

Question One: (a) Do you think the instructions provided for the Group Leader are sufficient? Please explain.

There was consensus among participants in the study regarding the instructions provided for the Group Leader in Session 2. Participants noted that the instructions were sufficient. They explained, “*The instructions are clear, sufficient, and easy to follow;*” “*The instructions add suggested material;*” “*The instructions flow from the first session;*” “*The order in which the instructions are presented will help the Group Leader to conduct the Session.*”

Question One: (b) Do you think the instructions provided for Group Members are sufficient? Please explain.

All participants in the study considered the instructions for Group Members in Session 2 were sufficient. They noted, “*The instructions sound like an invitation to work on the analysis of the case and to organize and facilitate the cognitive process;*” “*They [instructions] are enough to educate/inform Group Leaders to check in if Group Members are getting the material.*” One participant noted that the instructions to Group Members “*need to be in Spanish.*” Another participant reiterated her comment made in

Sessions 1, adding in the instructions the use a dry-erase board to facilitate discussion throughout the sessions.

Question Two: Do you think the questions provided to Group Members are sufficient? Please explain.

There was consensus among the participants regarding questions in Session 2 being sufficient for emphasizing treatment issues and helping Group Members practice what they learned during the session. All the participants indicated that the questions were sufficient and properly addressed treatment techniques. A representational statement was “*Questions are precise following from less to more intensive [components of treatment] and in close parallel with the chaining activity previously demonstrated. The questions are also precisely directed to each of the thought distortions presented in the vignette.*” Another participant stated, “*Questions are presented in a simple order and they go step by step from the first basic event to the final one. The Questions help Group Members make connection between thoughts and mood.*”

Question Three: In the vignette about Fernando, did I address cultural values/beliefs relevant to Hispanics/Latinos? Please specify. What was more helpful? What was less helpful?

Within the context of Session 2, which focused on “*Identifying Harmful Thoughts and Helpful Thoughts,*” participants in the study agreed that the vignette about Fernando succeeded in addressing Hispanics/Latinos’ cultural values. When asked about what was more helpful to them in the vignette, participants stressed the importance of addressing family support and involvement in times of trouble, and the importance of fulfilling traditional roles. A representational statement was “*The incorporation of family*

(*comadre Aurora and compadre Lorenzo*), *male role (kind of man that cannot provide)*, and *cultural values/perspectives with regard to health (first to the relatives instead of medical provider)*. Participants also noted, “*Mentioning Fernando’s wife participation;*” and “*Male provider of the family, feelings of disappointment, the wife asking her compadre for help.*” One of the participants emphasized the importance of using culturally sensitive terms. She noted, “*The use of culturally sensitive terms that Group Members can identify with. I like the use of words that are relevant to the target population. Also, it was easy to understand.*”

In the question about what was less helpful, three of the participants in the study stated that there was “*nothing*” that was not helpful. One of the participants seemed to be touched by certain circumstances that affected Fernando’s life, as described in the vignette, even though the participant recognized that those kinds of events take place in many Hispanics/Latinos’ lives. Her statement in the matter was “*Dramatizing Fernando’s situation with painful circumstance, such as his mother being sick, not getting a job ... not being able to support his family. In reality, these match the extensive population of Hispanic immigrants.*”

Question Four: What cultural values and/or beliefs you feel that needed to be addressed in the session, but were not addressed?

Three of the participants in the study did not identify any cultural value or belief relevant to Hispanics/Latinos that were not addressed in Session 2. One participant recommended that this researcher include a component that addresses Hispanics/Latinos’ distrust towards health care providers. The participant suggested the use of a proverb to address the matter related to “*The distrust on external providers; for example, ‘Los trapos*

sucios se lavan en casa (The dirty cloth should be washed at home).” Interestingly, in the study (Session 4: “How to Have More Helpful Thoughts to Improve Your Mood”), the researcher addressed Fernando’s difficulty in seeing a stranger (health care provider) and in telling his personal problems. The researcher included the use of proverbs in her recommendations, including the one suggested by the participant. Thus, there appears to be consensus in the relevance of the topic noted by the participant (distrust on providers) and the kind of culturally sensitive intervention (use of proverbs) that can help change the belief.

Question Five: Overall, in a scale from 0 (none) to 10 (most) please rate to what degree my suggestions addressed Hispanics/Latinos’ cultural values and beliefs?

When asked to rate the researcher’s suggestions for Session 2, one participant in the study rated the suggestions “10,” two participants rated the researcher’s suggestions “8,” and one participant rated the suggestions “7.” The mean score for the participants’ overall rating was 8.

Question Six: Is there any further recommendation you would add to make the treatment experience more culturally sensitive to Hispanic/Latino clients?

One participant stressed the importance of the role that *compadres* have in the lives of Hispanics/Latinos. She noted, “Consider introducing a brief statement in the vignette about cultural recommendations that *comadre Aurora* and/or *compadre Lorenzo* may add [to Fernando’s story], so that the cultural perspective of immediate collective action is portrayed.” The participant’s recommendation is important, because in the Hispanic/Latino culture, the *compadres* are considered extended family members, who have a very active role in family affairs and are highly influential within the family

system, and are strong source of support. Although the vignette in the present study makes reference to the persuasive involvement the *compadres* had in Fernando's life, future studies may consider elaborating further on the cultural intervention the *compadres* can provide for their love ones.

Another participant in the study suggested addressing the difficulty that Hispanic/Latino men have in expressing their feelings openly. Specifically, the participant noted, "*The inclusion of men's voices being silent (e.g., may not communicate or express feelings so openly in the family or to others, until they understand that is depression.)*" The participant's comment relates to the belief under which Hispanic/Latino individuals are raised, which teaches them that "men are strong"; "men do not cry"; "you must handle it as a man", and "only women cry." A treatment approach that educates Hispanic/Latino clients on the importance of identifying depression without questioning or challenging their cultural beliefs seems appropriate.

Question Seven: Is there any other comment you wish to add?

All participants in the study indicated that no additional comments were needed for Session 2. A representational statement was, "*The vignette, along with the questions for Group Members, is great. They are applicable and ensure members are learning the material in a practical way.*"

Session 3 – "Talking Back to Your Harmful Thoughts"

Question One: (a) Do you think the instructions provided for the Group Leader are sufficient? Please explain.

With regard to the instructions provided for the Group Leader in Session 3, all of the participants in the study indicated that the instructions were sufficient. Participants' representative statements were "*Instructions are clear;*" "*Easy instructions overall;*"

“Instructions help to put the material in the manual [Miranda’s] in perspective;”

“Instructions are easy to follow and the order in which they are presented will help

Group Leader to conduct the session.” One participant maintained her recommendation of adding the use of a dry-erase board in the instructions for the Group Leader in order to facilitate discussion throughout the sessions.

Question One: (b) Do you think the instructions provided for Group Members are sufficient? Please explain.

Regarding the instructions provided for Group Members in Session 3, the participants in the study indicated that they were sufficient. Participants considered the instructions clear, relevant to the module discussed, and contributed to the therapist’s leading role. One participant in the study stated, *“The instructions are clear and connect to the module information.”* “Another participant noted, *“It appears that the modeling and providing examples are focused on the Group Leader to help.”* For one participant, the instructions for Group Members eased clients’ self-disclosure.” Her statement was:

The instructions sound like a guide to analyze the case and facilitate the organization of cognitive processes. Instructions promote Group Members’ identification with Fernando’s story....The statement “I will later ask you about how you think and feel about Fernando” invites clients to manifest their own feelings and thoughts.

Providing Hispanic/Latino clients with simple and clear guidelines on what the focus of the session will be and facilitating their therapeutic processing in a non-confronting manner appear to be important.

Question Two: Do you think the questions provided to Group Members are sufficient? Please explain.

When asked about the questions for emphasizing treatment issues and helping Group Members practice what they learned during Session 3, two of the participants indicated that the questions suggested by the researcher were sufficient. One of these participant noted, *“I really like these questions, as they provide practical instructions.”* The other participant stated, *“I think the clients will be able to relate to Fernando in the vignette.”* The remaining two participants in the study added comments to enhance the questions for Group Members. One participant raised some concerns about the level of difficulty the questions would have for Hispanic/Latino clients with low level of education. Her comment is valid because clients’ cognitive strengths and weaknesses need to be taken into account so that their skills are not challenged in therapy sessions. Another participant provided the following recommendation:

Questions are clear and address most of Fernando’s statements. It can be added at the end what other thoughts Fernando could challenge, to determine if clients can identify “Yes, but they were not great jobs;” “This is worse than I thought,” and give the opportunity to do the true-false, accurate true analysis without immediate guide.

The participant’s comment stressed the importance of helping clients identify and challenge their “harmful thoughts” by facilitating cost-benefit analysis of such thoughts, which is an effective CBT technique.

Question Three: In the vignette about Fernando, did I address cultural values/beliefs relevant to Hispanics/Latinos? Please specify. What was more helpful? What was less helpful?

All participants in the study indicated that the vignette about Fernando in Session 3 addressed cultural values/beliefs relevant to Hispanics/Latinos. One participant noted,

“I liked how the vignette presented an overall theme of the basic cultural tradition for Latinos.” In discussing what was more helpful in the vignette, the area that emerged was the importance of family participation, which had the largest influence among the participants. For one participant, the most helpful was *“The incorporation of family responses. The fact that the compadre makes the appointment is consistent with cultural approaches.* Another participant stated, *“I like how Lorenzo encourages Fernando to get well.”* Other participant explained further,

The participation of the “compadre,” who emphasized positive memories about Fernando’s first jobs; reminding him that “his family needs him;” and effectively advising him “to see a doctor;” the compadre’s active intervention and help, when offers Fernando to set an appointment for him.

Some of the participants also recognized the importance of addressing in the vignette the stigma of mental health care as well as the mistrust towards health providers; these were intended to help Group members identify their own feelings of distrust. Representative statements about this topic were *“Fernando’s after thoughts of distrust of the system/providers;” “Feeling embarrassed, scared about mental health stigma.”*

When asked about what was less helpful in the vignette presented in Session 3, three of the participants in the study indicated that they did not find anything that was not helpful. Another participant considered Fernando’s automatic thoughts, such as *“This is worse than I thought”* and *“I am crazy,”* less helpful because they may prevent him from seeking help. Certainly these comments are relevant to the stigma that prevails among Hispanics/Latinos with regard to mental health issues.

Question Four: What cultural values and/or beliefs you feel that needed to be addressed in the session, but were not addressed?

Three of the four participants did not feel there were additional cultural values/beliefs that needed to be addressed in Session 3. Another participant in the study suggested that *“It may be helpful to address the perspective of Fernando’s wife regarding depression.”* Describing some thoughts that Hispanic/Latino clients’ spouses may have about what is happening to their loved ones can be valuable in helping these clients to seek help; however, it is also important to consider that challenging traditional roles expectations may not be appropriate within Hispanic/Latinos’ family systems.

Question Five: Overall, in a scale from 0 (none) to 10 (most) please rate to what degree my suggestions addressed Hispanics/Latinos’ cultural values and beliefs?

In rating the degree to which the researcher’s suggestions addressed Hispanics/Latinos’ values in Session 3, two participants in the study rated the researcher’s suggestions as “10,” one participant rated the suggestions as “9,” and another participant rated the suggestions as “8.” The mean score for the participants’ overall rating in this session was 9.

Question Six: Is there any further recommendation you would add to make the treatment experience more culturally sensitive to Hispanic/Latino clients?

With regard to additional recommendations that would make Session 3 more culturally sensitive to Hispanic/Latino clients, the overall consensus of the participants was that no additional suggestions were needed. A representational statement was *“I felt like the vignette was successful in making it appreciate to Latinos and easier to learn.”* One of the participants recommended to *“Add, at the end of the vignette, the compadre’s*

assurance that he will accompany Fernando if further treatment is needed.” The participant noted that, *“Social support can be an important mediator of treatment acceptance.”* The participant’s comment is relevant when considering the influential role that family members, including extended family such as the *compadre*, have in Hispanics/Latinos’ family affairs.

Question Seven: Is there any other comment you wish to add?

In relation to additional comments, the responses from the participants in the study varied. One of the participants did not find the need for additional comments. Another participant emphasized the way in which the researcher’s suggestions addressed both culturally sensitive components and mental health issues. Her statement was *“The vignette not only included culturally sensitive ideas, but also identified some symptoms of depression. I have to say this would also serve to normalize mental health issues for Latinos.”* Other participant recommended that considerations be given to making the specific suggestions in the session suitable for clients of all/different levels of education. These comments stressed the importance of finding therapeutic means by which mental health providers help their clients feel understood, comfortable, and supported when in therapy.

Session 4 – “How to Have More Helpful Thoughts to Improve Your Mood”

Question One: (a) Do you think the instructions provided for the Group Leader are sufficient? Please explain.

All participants stated that the instructions for the Group Leader in Session 4 were sufficient. Representational statements included, *“Instructions are clear;” “Instructions are easy to follow;” “I like the instructions at the beginning since it provide the direction to include the vignette;” “The instructions help outline the module.”*

Question One: (b) Do you think the instructions provided for Group Members are sufficient? Please explain.

The participants in the study noted that the instructions provided for Group members in Session 4 were sufficient. One participant stated, "*I think they [instructions] are very thorough and allow them [Group Members] to put ideas to practice.*" Another participant noted, "*Posting the questions at the beginning is a good introduction.*" The same participant recommended,

To give continuity to the first phrase "Let's practice how to have more helpful thoughts," I suggest saying "Let's remember some of Fernando's experiences and let's see new things that happened to him." At the end of the [instructions] paragraph consider stating "... how you think and feel about Fernando's experiences," instead of saying "... how you think and feel about Fernando."

These comments suggest that giving more specific instructions to Group Members may help emphasize what the focus of the session is in order to help clients identify critical issues better.

Question Two: Do you think the questions provided to Group Members are sufficient? Please explain.

In relation to the questions provided to Group Members in Session 4 to emphasize treatment issues and help them practice what they learned during the session, the participants in this study noted that the questions were sufficient. Participants stressed the importance of easing the therapeutic process within the session in a manner that elicits Hispanic/Latino clients' critical thinking and reflection, empowering them. One of the participants explained, "*Questions are helpful because they start immediate practice.*"

Questions proceed slightly through the vignette (third person), then places the participant in the position of advisor (still externalizing) to finally end with the participant himself, facilitating work through resistance.” Another participant noted, *“The questions gear what needs to be learned and allows them [Group Members] to keep it safe since they are first using the vignette.”*

Question Three: In the vignette about Fernando, did I address cultural values/beliefs relevant to Hispanics/Latinos? Please specify. What was more helpful? What was less helpful?

All participants noted that the vignette about Fernando in Session 4 succeeded in addressing Hispanic/Latino cultural values/beliefs. Religion, keeping problems within the family, and the use of proverbs were recognized as values associated with Hispanic/Latino culture, and important components in the vignette. Other components highlighted by the participants, as important to Hispanics/Latinos included distrust towards treatment providers, traditional roles expectations, and solving problems on their own, all which are supported by the literature. A representative statement about what seems more helpful was,

The initial decision of working on his own (very typical), the introduction of the “padrecito” (importance of religion, and the weight of two males’ opinion over his [Fernando’s] wife’s opinion. The use of proverbs. Reaffirmation of distrust of mental health provider (“Los trapos sucios se lavan en casa,” The dirty cloth should be washed at home.)

One participant indicated, *“I like the addition of the cultural values in the story, but I love the sayings as it is an important way Latinos communicate, too.”* Another participant

found more helpful the *“Inclusion of compadre and padrecito; wanting to keep issues inside the family.”* Another participant noted, *“Fernando tried to be hopeful. He talked not only with family members but the “padre,” who represents a social source to help Fernando make the right choice.”*

When answering what was less helpful in the vignette about Fernando, two of participants in the study did not identify anything that was not helpful. Two of the participants provided the following comments, *“I wonder if the length of the vignette would make it difficult to track the ideas;”* and *“I think it would be helpful to consider how the wife feels about diagnosis of depression.”* These are valid recommendations that can be explored in future studies.

Question Four: What cultural values and/or beliefs you feel that needed to be addressed in the session, but were not addressed?

Participants in the study did not identify any cultural values/beliefs relevant to Hispanics/Latinos that were not addressed in Session 4.

Question Five: Overall, in a scale from 0 (none) to 10 (most) please rate to what degree my suggestions addressed Hispanics/Latinos’ cultural values and beliefs?

In rating the degree to which the researcher’s suggestions addressed Hispanics/Latinos’ values in Session 4, one participant in the study rated the researcher’s suggestions as “10”; two participants rated the suggestions as “9,” and other participant rated the suggestions as “9.5” The mean score for the participants’ overall rating in this session was 9.

Question Six: Is there any further recommendation you would add to make the treatment experience more culturally sensitive to Hispanic/Latino clients?

When asked to provide recommendations to add more cultural sensitivity to the treatment experience described in Session 4, two of the participants indicated that they would not add anything. One participant recommended adding, “*A comment from Fernando’s mother (after talking to Fernando’s wife) supporting seeking treatment for Fernando.*” This is a valuable recommendation that would reaffirm the value of traditional roles within the Hispanic/Latino culture. Women, especially wives and mothers, assume strong nurturing and caretaking role within the Hispanic/Latino family system, and wives and mothers tend to have a partnership in looking for and planning what is best for the husband/son. Another participant in the study reiterated her prior recommendation of considering “*how the wife feels about diagnosis of depression.*”

Question Seven: Is there any other comment you wish to add?

Three of the participants in the study noted that they had no comment to add for Session 4. Another participant in the study emphasized the need to develop a vignette that is not centered only on a male character. She stated, “*The researcher provides a guide only for Hispanic/Latino males and apply the characteristics that are described in the content of the 4 vignettes.*” Participant’s comment supports the researcher’s expectation that future studies in this area will focus on female a character and takes into account cultural values that are more relevant to Hispanic/Latino women’s role.

The table below provides a breakdown of the participants' rating relative to researcher's suggestions.

Participant	Session 1 "Your Thoughts and Mood are Connected"	Session 2 "Identifying Harmful Thoughts and Helpful Thoughts"	Session 3 "Talking Back to Your Harmful Thoughts"	Session 4 "How to Have More Helpful Thoughts to Improve Your Mood"
P1	9	8	10	10
P2	9	10	10	9.5+
P3	8	8	8	9
P4	7	7	9	9

Table 2. Participants' rating with regard to researcher's recommendations

Question: Overall, in a scale from 0 (none) to 10 (most), please rate to what degree my suggestions address Hispanics/Latinos' cultural values and beliefs?

CHAPTER FIVE

Discussion

The present study was conducted to develop culturally sensitive treatment suggestions for Group CBT for Hispanic/Latino clients with depression and to examine the suitability and relevance of those suggestions, by seeking review and comments from 10 bilingual clinicians. The study concentrated on the First Module (Sessions 1 thru 4) of Miranda's Members' Guidebook (*"Guia para Miembros del Grupo"*). The study was motivated by the desire to increase awareness on the already acknowledged need for cultural sensitivity in the field of psychology, and contribute to the improvement, accessibility, and efficacy of cognitive therapy for adult Hispanic/Latino clients diagnosed with depression. Specifically, the study sought to make a contribution in the implementation of culturally sensitive treatment techniques that could help increase treatment retention of Hispanic/Latino male clients, whom scholars in the literature describe as prone to having more negative attitudes than women toward mental health treatment, and less likely to seek mental health services (Addis & Mahalik, 2003; Gonzales, Alegria, & Prihoda, 2005; O'Brien, Hunt, & Hart, 2005), including Puerto Rican, Mexican, and Cuban men (Peifer, Hu, & Vega, 2000). The development and implementation of a vignette with a male centered approach was suggested in the present study not only for these reasons but also to give attention to gender role expectations that are traditionally differentiated in the Hispanic/Latino culture.

In this section, a discussion of findings, limitations of the study, and implications for future research and practice are presented. In spite of the sample size that limited the identification of themes in the study, the open-ended questions format of this qualitative

study elicited valuable comments from the participants regarding the importance of addressing specific cultural values and beliefs in therapy sessions to make the treatment experience more culturally sensitive to Hispanic/Latino clients. Consistent with the literature regarding Hispanics/Latinos, there was consensus among the participants in the study about the importance of family (“*familismo*”), proverbs (“*dichos/refranes*”), religion, traditional gender roles’ expectations (*Machismo-Marianismo*), the influence of family/social network (*compadres, priest*), and the stigma associated with mental health services. The participants found that this researcher’s suggestions for making Group CBT more culturally sensitive to Hispanic/Latino clients with depression succeeded in incorporating the values and beliefs embraced by this minority group. They also provided some recommendations that would complement the researchers’ suggestions.

For the participants in this study, providing simple, clear, and concise guidelines on what the focus of the session would be, and facilitating the therapeutic process in a non-confronting manner was very important. With regard to the vignette developed for this study, participants’ appraisal was that Hispanic/Latino clients would be able to relate to Fernando’s story. Representative statements “*I liked how the vignette presented an overall theme of the basic cultural tradition for Latinos;*” “*The vignette not only included culturally sensitive ideas, but also identified symptoms of depression, which would help normalize mental health issues for Latinos;*” and “*Questions for Group Members are helpful for them to make connection between Thought and Mood,*” support the relevance of those constructs this study sought to address, Hispanic/Latino cultural values, Depression, and CBT.

An important finding was that participants' treatment orientation did not seem to be an issue regarding their identification and appreciation of Hispanic/Latino clients' cultural values and beliefs that were implemented to add cultural sensitivity to CBT methods. Only one of the four participants in the study identified herself as a CBT clinician. All four participants provided their comments without raising concerns with regard to the application of specific CBT approaches, suggesting endorsement of the clinical intervention as described in the study.

Interestingly, one of the participants in the study raised questions with regard to traditional gender-role expectations, which addressed *Marianismo*, described in the vignette about Fernando. The participant noted that Hispanic/Latino women, who were more highly educated, would endorse less traditional values. This statement agrees with the literature review indicating that more strongly acculturated and more highly educated Hispanic/Latino women tend to be egalitarian and experience less conflict about not practicing traditional cultural values. However, the literature also emphasizes the fact, that although controversial, *Marianismo* remains a Hispanic/Latino cultural value (Santiago-Rivera, Arredondo, Gallardo-Cooper, 2002). Given the polemic in this topic, further research is needed to study the impact of the changes in traditional Hispanics/Latinos' gender role expectations caused by acculturation, relative to psychotherapy.

Implications for Best Practices

Clearly, there is an urgent need to increase the effectiveness of psychotherapy with Hispanics/Latinos and their treatment retention. According to the U.S. Census Bureau, in 2010 one in five Americans will identify as Hispanic with cultural ties to

Spanish speaking countries, such as Mexico, Cuba, and El Salvador. The U.S. Census Bureau also projects that by the year 2035, in some areas of the country (e.g., Texas), Hispanics/Latinos may outnumber Caucasians. The rapid growth of this population suggests an increasing demand for psychologists' readiness to provide mental health services that are attentive and sensitive to Hispanics/Latinos' unique cultural values and beliefs. Otherwise, the first contact that Hispanics/Latinos make with mental health providers to seek psychotherapy may also be their last one, which creates a significant disparity in the access to mental health care by Hispanics/Latinos (U. S. Department of Health & Human Services [USDHHS], 2001; American Psychiatric Association [APA], 2007). These clients are at high risk for never returning to a psychologist after the first session, primarily because they do not feel understood (Altarriba, 2003; Fraga, Atkinson, & Wampold, 2004).

Although significant progress has been made in increasing clinicians' multicultural awareness, the field of psychology lacks research that compares treatment interventions tailored to Hispanic/Latino clients with psychotherapy, as usual. The present study promotes the development and implementation of strategies that focus on Hispanic/Latino values to improve psychotherapy interventions and decrease the clients' drop-out rate. The more clinicians learn about the Hispanic/Latino culture and subgroups, the better prepared they will be to provide the quality of mental health care these clients deserve.

Psychologists must continue learning about the cultural framework that Hispanic/Latino clients bring to treatment sessions. Increasing the number of bilingual psychologists may lead more Hispanics/Latinos to pursue mental health care. However,

learning to speak Spanish is not enough for increasing these clients' access to psychological services or their adherence to treatment. Psychologists need to acquire and implement skills that help their Hispanic/Latino clients feel understood. Because there are not enough Hispanic/Latino psychologists, non-Hispanic/Latino psychologists must find the means to better serve these clients. Learning, understanding, discussing, and embracing these clients' cultural values and beliefs may be the key to improving treatment outcomes and decreasing their drop-out rate.

Speaking clients' native language (Spanish) helps the clients feel understood and more comfortable when reporting emotions and life episodes. Even Hispanics/Latino clients who are fluent in English tend to speak selectively in their native language to express emotions or relate feelings to others. This should not discourage non-Spanish-speaking clinicians in their efforts to help these clients. In agreement with the literature and the feedback provided by the participants in this study, non-Spanish-speaking clinicians are encouraged to learn and become familiar with the proverbs (*dichos*) that can be an important tool to relate and communicate with Hispanic/Latino clients within the therapeutic setting. Given that these proverbs are brief, non-Spanish-speaking clinicians can learn to say them in Spanish. However, they must be aware of the variations in the meanings offered in proverbs (*dichos*). Clinicians are encouraged to seek consultation with knowledgeable Hispanic/Latino colleagues who can guide them in the use of proverbs. This practice would help non-Hispanic/Latino clinicians acknowledge the importance of their clients' culture. They would be using proverbs to make a therapeutic point, without being misinterpreted or appearing disrespectful. When non-Spanish-speaking clinicians learn to pronounce the *dichos* in Spanish, they can

promote the cultural atmosphere that helps traditional Hispanic/Latino clients feel more comfortable. Non-Latino and non-Spanish-speaking clinicians can count on their Hispanic/Latino clients in helping them to practice the pronunciation of the *dichos*, while strengthening their therapeutic relationship.

Limitations of the Study

There are several limitations to this study that must be acknowledged. The researcher encountered difficulty in accessing bilingual clinicians to participate in this study. As a result, the small sample size limits the generalizability of the study. In spite of their interest to contribute to the literature that would increase cultural sensitivity of Hispanic/Latino clients, bilingual mental health providers hesitated to participate in the present study because of their busy schedules and lack of available time. Initially, 8 of the 10 participants required for the study agreed to be in the study, but only 4 completed the study. This limitation seemed to be associated with the significant amount of reading material and the number of questions that clinicians were asked to complete at various stages of the study. A future study may consider more creative ways to compensate clinicians for the time they are willing to devote to the study, such as a gift certificate to a restaurant or department store, or a symbolic financial compensation for the time they otherwise would give to clients that pay for their services.

There were also limitations with regard to the diversity of the sample, including gender and therapeutic orientation. All four participants in the study were female clinicians, with three of them identifying their orientation as Existentialist. Future research should strategize efforts to recruit male therapists and participants from different therapeutic orientations.

The qualitative method of this study also has limitations. The researcher's subjective perceptions and interpretations, and personal expectations may have influenced the conclusions extracted from the data in a manner that is considered less reliable and less empirical. Furthermore, the researcher's personal background as Latina and as an immigrant may add biases to the study. In exploring her individual bias and expectations, this researcher identified her belief that participants would embrace the values associated with family, religion, and traditional gender role expectations.

Another limitation relevant to this qualitative study was the absence of an external consultant to monitor the objectivity of the study. This researcher was unable to pursue a qualified auditor, due to the small sample size and limited time to complete the study for dissertation purpose. There were also limitations associated with the use of electronic mail. All participants in the study agreed to participate in it as long as the communication and follow-up on their work, related to the study, was done via electronic mail and within their own schedules. As a result, there was no face to face contact between the researcher and the participants, and phone contact was limited to leaving voice mail messages. The researcher had no opportunity to observe participants' body language or changes in their tone of voice, which would have yield additional qualitative data.

Recommendations for Future Research

Psychologists need to do further investigations on the core values and beliefs of Hispanics/Latinos that can help this population decide to seek mental health care; these values and beliefs include their sense of family obligations, fulfilling traditional roles' expectations, and improving relationships with social network. It is also important that

through research, psychologists help diminish the stigma that Hispanics/Latinos attribute to receiving psychological services (e.g., “people will think I am crazy”).

The present study advocates the theory that to maximize treatment retention and outcomes when providing mental health services to Hispanic/Latino clients diagnosed with depression, traditional CBT may be modified to improve the match of these clients’ cultural contexts. However, this researcher recognizes that the small sample size in the study provides results that can be considered only preliminary and replication of the study is warranted.

Hopefully, this study will encourage further research to complete the cultural adaptation of the two remaining modules of Miranda’s Group Members’ Guidebook (“*Guia para Miembros del Grupo*”); this may guide other graduate students in determining whether or not they should take similar or different directions to complete the task. Replicating the present study with a more significant sample size, and more diversity in gender and in treatment orientation may be the next step to take in this process. Given that bilingual clinicians are in high demand and they seem to have no available time to participate in studies such as this, future researchers must weigh the possibility of compensating them financially for their time; that is, paying them for an appointment time that they would have otherwise assigned to a client.

Research is needed that help investigate the extent to which Hispanic/Latino clients do indeed benefit from CBT methods that are tailored to be more culturally sensitive to Hispanics/Latinos. Furthermore, future research should examine whether or not clinicians that implement culturally sensitive treatment methods with Hispanic/Latino

clients have better treatment outcomes with their clients than those clinicians who practice psychotherapy as usual.

A vignette centered on a female character and vignettes written in both the English and Spanish languages need to be developed for consideration in future research that seeks to implement cultural sensitivity when providing mental health care to Hispanic/Latino clients. Future study may consider seeking feedback from Hispanic/Latino clients with regard to the recommendations formulated for making group CBT culturally sensitive to their cultural beliefs/values. Clients' comments would provide an important perspective on how culturally relevant and appropriate those recommendations are.

This researcher hopes that the present study contributes somewhat to the emerging body of literature that has begun recognizing the unique mental health needs faced by Hispanics/Latinos in U.S. Culturally sensitive psychotherapy offers an important opportunity for psychologists to provide mental health services to Hispanic/Latino individuals by giving them the opportunity to share and have their unique emotional and personal life experiences validated. Treatment retention of these clients will remain deficient as long as they believe and feel that mental health providers do not understand them.

CHAPTER SIX

References

- Addis, M. E., & Mahalik, J. R. (2003). Men, masculinity, and the contexts of help seeking. *American Psychologist, 58*, 5-14.
- Alegria, M., Canino, G., Ríos, R., Vera, M., Calderón, J., Rusch, D., et al. (2002). Inequalities in use of specialty mental health services among Latinos, African-American and non-Latino Whites. *Psychiatric Services, 53*, 1547-1555.
- Altarriba, J. (2003). Does cariño equal "liking"? A theoretical approach to conceptual nonequivalence between languages. *International Journal of Bilingualism, 7*, 305-322.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: Author.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text revision). Washington, DC: Author.
- American Psychiatric Association. (2007). *Mental health in the Hispanic/Latino community*. Retrieved October 08, 2008, from <http://www.healthyminds.org>
- American Psychological Association. (2002). Guidelines on multicultural education, training, research, practice, and organizational change for psychologists. *American Psychologist, 58*, 377-402.
- American Psychological Association. (2005). APA 2020: A perfect vision for psychology. *American Psychologist, 60*, 512-522.
- American Heritage Dictionary of the English Language (4th ed.). (2000). Retrieved April 25, 2008, from <http://www.bartleby.com/61/60/H0216000.html>

- Arean, P. A., & Cook, B. L. (2002). Psychotherapy and combined psychotherapy/pharmacotherapy for late life depression. *Society of Biological Psychiatry*, 52, 293-303.
- Arredondo, P., & Tazeau, Y. N. (2005). Latinas/Latinos in Counseling: A cultural, strengths-based approach. *PsychCritiques* 50, 38, [no page #]
- Barter, Ch., & Renold, E. (1999). *Social research update: The use of vignettes in qualitative research*. Retrieved July 28, 2009, from <http://sru.soc.surrey.ac.uk/SRU25.html>
- Bean, R. A., Perry, B. J., & Bedell, T. M. (2001). Developing culturally competent marriage and family therapists: Guidelines for working with Hispanic families. *Journal of Marital and Family Therapy*, 27, 43-54.
- Beck, A. T., Rush A. J., & Shaw B. F. (1979). *Cognitive therapy of depression*. New York: Guilford Press.
- Beck, A. T., Rush, A. J., Shaw, B.F., & Emery, G. (1987). *Cognitive therapy of depression*. New York: Guilford Press.
- Beck, A. T., & Steer, R. A. (1993). *Manual for Beck Depression Inventory*. San Antonio, TX: Psychological Corporation.
- Beck, J. S. (1995). *Cognitive therapy: Basics and beyond*. New York: Guilford Press.
- Berry, J. W, (2002). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Advances in theory, measurement, and applied Research* (pp. 17-37). Washington DC: American Psychological Association.
- Berry, J. W, (2003). Conceptual approaches to acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement,*

- and applied research* (pp. 17-37). Washington, DC: American Psychological Association.
- Bonilla, J., Bernal, G., Santos, A., Santos, D. (2004). A revised Spanish version of the Beck Depression Inventory: Psychometric properties with a Puerto Rican sample of college students. *Journal of Clinical Psychology, 60*, 119-130.
- Boss, P., Dahl, C., & Kaplan, L. (1996). The use of phenomenology for family therapy Research: The search for meaning. In D. H. Sprenkle & S. M. Moon (Eds.), *Research methods in family therapy* (pp. 83-106). London: Guilford Press.
- Brennan, J. F. (2003). *History and systems of psychology* (6th ed.). India: Pearson Education, Inc.
- Broadhead, W. E., Blazer, D. G., George, L. K., & Tse, C. K. (1990). Depression, disability days, and days lost from work in a prospective epidemiologic survey. *Journal of the American Medical Association, 264*, 2524-2528.
- Butler, A. C., Chapman, J. E., Forman, E. M., & Beck, A. T. (2006). The empirical status of cognitive-behavior therapy: A review of meta-analyses. *Clinical Psychology Review, 26*, 17-31.
- Cabassa, L. J. (2007). Latino immigrant men's perceptions of depression and attitudes toward help seeking. *Hispanic Journal of Behavioral Science, 29*, 492-509.
- Cabassa, L. J., & Zayas, L. H. (2007). Latino immigrants' intentions to seek depression care. *American Journal of Orthopsychiatry, 77*, 231-242.
- Castonguay, I., Golfried, M., Wisner, S., Raue, P., & Hayes, A. (1996). Predicting the effect of cognitive therapy for depression: A study of unique and common factors. *Journal of Consulting and Clinical Psychology, 64*, 497-504.

- Centers for Disease Control and Prevention. (2004). Suicide among Hispanic, United States, 1997-2001. *Morbidity and Mortality Weekly Report*, 53, 478-481.
- Chambless, D. (1996). In defense of dissemination of empirically supported psychological interventions. *Clinical Psychology: Science and Practice*, 3, 230-235.
- Chambless, D., & Hollon, S. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7-18.
- Chen, H., Kramer, E. J., Chen, T., & Chung, H. (2005). Engaging Asian Americans for mental health care research: Challenges and solutions. *Journal of Immigrant Health*, 7, 109-116.
- Cochran, S. V., & Rabinowitz, F. E. (2000). *Men and depression: Clinical and empirical perspectives*. San Diego, CA: Academic Press.
- Comas-Diaz, L. (1997). Mental health needs of Latinos with professional status. In J.G. Garcia & M. C. Zea (Eds.), *Psychological interventions and research with Latino Populations* (pp. 142-165). Needham Heights, MA: Allyn & Bacon.
- Cooper, L. A., Gonzales G. G., Gallo, J. J., Rost, K. M., Meredith, L. S., Rubenstein, L.V., et al. (2003). The acceptability of treatment for depression among African-American, Hispanic, and White primary care patients. *Medical Care*, 41, 479-489.
- Creswell, J. W. (2009). *Research design*. Sage Publications, CA: Thousand Oaks.
- Dana, R. H. (Ed.). (2000). *Handbook of cross-cultural and multicultural personality assessment*. Mahwah, NJ: Erlbaum.
- DeRubeis, R. J., & Crits-Christoph, P. (1998). Empirically supported individual and group psychological treatments for adult mental disorders. *Journal of Consulting*

- and Clinical Psychology, 66, 37-52.*
- Dittman, M. (2003). A changing study body. *Monitor on Psychology, 34, 42.*
- Dowd, E. T. (2003). Cultural differences in cognitive therapy. *Behavior Therapist, 26, 247-249.*
- Dubovsky, S. L., Davies, R., & Dubovsky, A. N. (2003). Mood disorders. In Hales, R. E., & Yudofsky, S. C. (Eds.), *Textbook of clinical psychiatry* (4th ed.). Retrieved September 09, 2007, from <http://www.psychiatryonline.com>
- Dwight-Johnson, M., Lagomasino, I. T., Aisenberg, E., & Hay, J. (2004). Using conjoint analysis to assess depression treatment preferences among low-income Latinos. *Psychiatric Services, 55, 934-936.*
- Dwight-Johnson, M., Sherbourne, C. D., Liao, D., & wells, K. B. (2000). Treatment preferences among depressed primary care patients. *Journal of General Internal Medicine, 15, 527-534.*
- El Boricua (n. d.). *A monthly, cultural publication for Puerto Ricans. Latinos or Hispanics.* Retrieved April 22, 2008, from http://www.elboricua.com/latino_hispanic.html
- Falicov, C. F. (1998). *Latino families in therapy: A guide to multicultural practice.* New York: Guilford.
- Flores, G. (2000). Culture and the patient-physician relationship: Achieving cultural competency in health care. *The Journal of Pediatrics, 136, 14-23.*
- Fraga, E. D., Atkinson, D. R., & Wampold, B. E. (2004). Ethnic group preferences for multicultural counseling competencies. *Cultural Diversity and Ethnic Minority Psychology, 10, 53-65.*

- Frasure-Smith, N., Lesperance, F., & Talajic, M. (1993). Depression following myocardial infarction: Impact on 6-month survival. *Journal of the American Medical Association, 270*, 1819-1825.
- Garfield, S. L. (1996). Some problems associated with “validated” forms of psychotherapy. *Clinical Psychology: Science and Practice, 3*, 218-229.
- Givens, J. L., Houston, T. K., van Voorhees, B. W., Ford, D. E., & Cooper, L. A. (2007). Ethnicity and preferences for depression treatment. *General Hospital Psychiatry, 29*, 182-191.
- Glied, S., & Kofman, S. (1995). *Women and mental health: Issues for health reform*. New York: The Commonwealth Fund, Commission of Women’s Health.
- Gonzales, J. M., Alegria, M., & Prihoda, T. J. (2005). How do attitudes toward mental health treatment vary by age, gender, and ethnicity in young adults? *Journal of Community Psychology, 33*, 611-629.
- Greenberg, D., & Padesky, C.A. (1995). *Mind over mood*. New York: Guilford Press.
- Greenberg, P. E., Stiglin, L. E., Finkelstein, S. N., & Berndt, E. R. (1993). Depression: A Neglected major illness. *Journal of Clinical Psychiatry, 54*, 419-424.
- Gross, J. J., & Munoz, R. F. (1995) Emotion regulation and mental health. *Clinical Psychology: Science and Practice, 2*, 151-164.
- Guarnaccia, P. J., Lewis-Fernández, R., & Rivera Marano, M. (2003). Toward a Puerto Rican popular nosology: Nervios and ataque de nervios. *Culture, Medicine, and Psychiatry, 27*, 339-366.
- Guarnaccia, P. J., Martinez, I., & Acosta, H. (2002). *Comprehensive in-depth literature review and analysis of Latino mental health issues*. With specific focus on

- members of the following ethnic groups: Cubans, Dominicans, Mexicans, and Puerto Ricans. Report summoned by and property of: Changing Minds, Advancing Mental Health for Latinos. New Jersey Mental Health Institute.
- Hall, G. C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502-510.
- Hays, P. A. (1995). Multicultural applications of cognitive-behavior therapy. *Professional Psychology: Research and Practice, 26*, 309-315.
- Hays, P. A., Iwamasa, G. Y. (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. Washington DC: American Psychological Association.
- Hildebrand, V., Phenice, L. A., Gray, M. M., & Hines, R. P. (2000). *Knowing and serving diverse families* (2nd ed.). Upper Saddle River, NJ: Prentice-Hall
- Hobfoll, S. E. (1998). *Stress, culture and community: The psychology and philosophy of stress*. New York: Plenum Press.
- Hovey, J. D. (2000). Acculturative stress, depression, and suicidal ideation among Mexican immigrants. *Cultural Diversity and Ethnic Minority Psychology, 6*, 134-151.
- Institute of Medicine. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care* (executive summary). Retrieved August 07, 2009 from <http://www.allhealth.org/BriefingMaterials/UnequalTreatment-56.pdf>
- Interian, A., & Diaz-Martinez, A. M. (2007). Considerations for culturally competent cognitive-behavioral therapy for depression with Hispanic patients. *Cognitive and Behavioral Practice, 14*, 84-97.

- Iwamasa, G., & Smith, S. K. (1996). Ethnic diversity and behavioral psychology: A Review of the literature. *Behavior Modification, 20*, 45-49.
- Ji, L.J., Nisbett, R. E., & Sue, Y. (2001). Culture, change, and perception. *Psychological Science, 12*, 450-456.
- Katon, W., & Sullivan, M. D. (1990). Depression and chronic mental illness. *Journal of Clinical Psychiatry, 51*, 3-14.
- Kazdin, A. E. (2003). *Research design in clinical psychology*. (2nd ed.). Boston, MA: Allyn & Bacon.
- Kouyoumdjian, H., Zamboanga, B. L., & Hansen, D. J. (2003). Barriers to community mental health services for Latinos: Treatment consideration. *Clinical Psychology: Science and Practice, 10*, 394-422.
- LaFarelle, L. (n. d.). *Latinos or Hispanics?* Retrieved on August 07, 2009, from <http://www.elboricua.com/Articles.html>
- LaFromboise, T., Coleman, H. L. K., & Gerton, J. (1993). Psychological impact of biculturalism: Evidence and theory. *Psychological Bulletin, 114*, 395-412.
- Lara, M. A., Navarro, C., Rubi, N. A., Mondragón, L. (2003). Outcome results of two levels of intervention in low-income women with depressive symptoms. *American Journal of Orthopsychiatry, 73*, 35-43.
- Lewis-Fernandez, R., Das, A. K., Alfonso, C., Weissman, M. M., & Olfson, M. (2005). Depression in US Hispanics: Diagnostic and management considerations in family practice. *Journal of the American Board of Family Practice, 18*, 282-296.
- Lo, H. T., & Fung, K. P. (2003). Culturally competent psychotherapy. *Canadian Journal of Psychiatry, 48*, 161-70.

- Long, G. (1991). *Enchiridion Epictetus*. Amherst, NY: Prometheus Books.
- Marin, G. (1992). Issues in the measurement of acculturation among Hispanics. In K.F. Geisinger (Ed.), *Psychological testing of Hispanics* (pp. 235-251). Washington, DC: American Psychological Association.
- Marin, G. (1993). Influence of acculturation on familialism and self-identification among Hispanics. In M.E. Bernal & G. P. Knight (Eds.), *Ethnic identity: Formations and transmissions among Hispanics and other minorities* (pp. 181-196). Albany: State University of New York Press.
- Marin, G., & Marin, B. V. (1991). *Research with Hispanic populations*. Newbury Park, CA: Sage.
- Martinez, C. (2000). Conducting the cross-cultural clinical interview. In I. Cuellar & F. A. Paniagua (Eds.), *Handbook of multicultural health assessment and treatment of diverse populations* (pp. 311-322). New York: Academic Press.
- Martinez, I. E., & Guarnaccia, P. J., (2007). "It is like going through an earthquake": Anthropological perspectives on depression among Latino immigrants. *Journal of Immigrant Minority Health, 9*, 17-28.
- Masuda, T., & Nisbett, R. E. (2001). Attending holistically versus analytically: comparing the context sensitivity of Japanese and Americans. *Journal of Personality and Social psychology, 81*, 922-934.
- McGrath, E., Keita, G. P., Stickland, B. R., & Russo, N. F. (1990). *Women and depression: Risk factors and treatment issues*. Washington, DC: American Psychological Association.

- Mendoza, R. H., (1989). An empirical scale to measure type and degree of acculturation in Mexican-American adolescents and adults. *Journal of Cross-Cultural Psychology*, 20, 372-385.
- Mineka, S., Watson, D., & Clark, L. A. (1998). Comorbidity of anxiety and unipolar mood disorders. *Annual Review of Psychology*, 49, 377-412.
- Miranda, J. (1996). Introduction to the special issue on recruiting and retaining minorities in psychotherapy research. *Journal of Consulting and Clinical Psychology* 64, 848-850.
- Miranda, J., Azocar, F., Organista, K., Dwyer, E., & Areal, P. (2003). Treatment of Depression among impoverished primary care patients from ethnic minority groups. *Psychiatric Services*, 54, 219-225.
- Miranda, J., Chung, J. Y., Green, B. L., Krupnick, J., Siddique, J., Revicki, D. A., et al. (2003). Treating depression in predominately low-income young minority women: A randomized controlled trial. *Journal of the American Medical Association*, 290, 57-65.
- Miranda, J., Green, B. L., Krupnick, J., Chung, J. Y., Siddique, J., Belin, T., et al. (2006). One-year outcomes of a randomized clinical trial treating depression in low-income minority women. *Journal of Consulting and Clinical Psychology*, 74, 99-111.
- Miranda, J., Lawson, W., & Escobar, J. I. (2002). Ethnic minorities. *Mental Health Services Research*, 4, 231-337.
- Miranda, J., Woo, S., Lagomasino, I., Hepner, K., Wiseman, S., & Muñoz, R. (2006). *Guía para miembros del grupo: Pensamientos, actividades, personas, y su estado*

- de ánimo*. Spanish closed group manual for group members. Clínica de tratamiento cognitivo-conductual para la depresión, División de Medicina Psicosocial Hospital General de San Francisco, Universidad de California, San Francisco.
- Moller-Leimkuhler, A. M. (2002). Barriers to help-seeking by men: A review of sociocultural and clinical literature with particular reference to depression. *Journal of Affective Disorders, 17*, 1-9.
- Munoz, R. F. (1995). Toward combined prevention and treatment services for major depression. In C. Telles & M. Karno (Eds.) *Latino Mental Health: Current Research and Policy Perspectives* (pp.183-200). Los Angeles: University of California, Los Angeles, Neuropsychiatric Institute.
- Munoz, R. F., Ghosh Ippen, C., Rao, S., & Dwyer, E. V. (2000). *Manual for group cognitive-behavioral therapy of major depression: A reality management approach*. San Francisco: San Francisco General Hospital Cognitive-Behavioral Depression Clinic.
- Murray, C. J., & Lopez, A. D. (1996). Evidence-based health policy: lessons from the Global Burden of Disease Study. *Science, 274*, 740-743.
- Nagayama Hall, G. C. (2001). Psychotherapy research with ethnic minorities: Empirical, ethical, and conceptual issues. *Journal of Consulting and Clinical Psychology, 69*, 502-510.
- National Institute of Mental Health. (2000). *Depression*. Retrieved July 24, 2007, from <http://www.nimh.gov>

- National Institute of Mental Health. (2003). *Breaking ground, breaking through: The strategic plan for mood disorders research* (DHSS Publication No. 03-5121). Washing, DC: U.S. Government Printing Office.
- National Institute of Mental Health. (2005). *Depression: What every woman should know*. A fact sheet describing the symptoms and reasons why women are more likely than men to suffer depression. Retrieved July 23, 2007, from <http://www.nimh.nih.gov/publicat/depwomenknows.cfm>
- National Institute of Mental Health. (2006). *The numbers count: Mental disorders in America*. A fact sheet describing the prevalence of mental disorders in America. Retrieved July 23, 2007, from <http://www.nimh.gov/publicat/numbers.cfm>
- National Institute of Mental Health. (2008). *Science news: Maintenance treatment crucial for teen's recovery for depression*. Retrieved April 22, 2008, from <http://www.nimh.nih.gov/science-news/2008/maintenance-treatment-crucial-for-teens-recovery-from-depression.shtml>
- Norenzayan, A., & Nisbett, R. E. (2000). Culture and causal cognition. *Current Directions and Psychological Science*, 9, 132-135.
- Novas, H. (2008). *Everything you need to know about Latino history*. London, England: Penguin Group.
- O'Brien, R., Hunt, K., & Hart, G. (2005). "It's caveman stuff, but that is to a certain extent how guys still operate:" Men's accounts of masculinity and help-seeking. *Social Science and Medicine*, 61, 503-516.
- Organista, K. C. (2000). Latinos. In J. R. White & A. Freeman (Eds.), *Cognitive-behavioral group therapy: For specific problems and populations* (pp. 281-303).

- Washington DC: American Psychological Association.
- Organista, K. C. (2006). Cognitive-behavioral therapy with Latinos and Latinas. In P.A. Hays & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice and supervision* (pp. 73-96). Washington DC: American Psychological Association.
- Organista, K. C., & Muñoz, R. F. (1996). Cognitive-behavioral therapy with Latinos. *Cognitive and Behavioral Practice, 3*, 255-270.
- Organista, K. C., Munoz, R. F., & Gonzalez, G. (1994). Cognitive-behavioral therapy for Depression in low-income and minority medical outpatients: Description of a program and exploratory analyses. *Cognitive Therapy and Research, 18*, 3.
- Ortega, A. N., & Alegria, M. (2002). Self-reliance, mental health need, and the use of mental health care among island Puerto Ricans. *Mental Health Service Research, 4*, 131-140.
- Palloni, A., & Morenoff, J. D. (2001). Interpreting the paradoxical in the Hispanic paradox: Demographic and epidemiologic approaches. *Annals of the New York Academy of Science, 954*, 140-174.
- Plant, E. A., & Sachs-Ericsson, N. (2004). Racial and ethnic differences in depression: The roles of social support and meeting basic needs. *Journal of Consulting and Clinical Psychology, 72*, 41-52.
- Peifer, K. L., Hu, T., & Vega, W. (2000). Help seeking by persons of Mexican origin with functional impairments. *Psychiatric Services, 51*, 293-1298.
- Pescosolido, B. A., Wright, E. R., Aleria, M., & Vera, M. (1998). Social networks and patterns of use among the poor with mental health problems in Puerto Rico.

- Medical Care*, 36, 1057-1072.
- Pope-Davis, D. B., & Coleman, H. L. K. (1997). *Multicultural counseling competencies: Assessment, education and training, and supervision*. Thousand Oaks, CA: Sage.
- Posner, S. F., Stewart, A. L., Marin, G., & Perez-Stable, E. J. (2001). Factor variability of the Center for Epidemiological Studies Depression Scale (CES-D) among urban Latinos. *Ethnicity and Health*, 6, 137-144.
- Poulou, M. (2001). The role of vignettes in the research of emotional and behavioural difficulties. *Emotional and Behavioral Difficulties Research*, 6, 50-62.
- Pumariega, A. (2007). Stigma of mental illness in the Hispanic/Latino community. *Healthy Minds of the American Psychiatric Association*. Retrieved on October 10, 2008, from <http://healthyminds.org/hispanicmh.cfm>
- Radloff, L. S. (1977). The CES-D) Scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1, 385-401.
- Reinecke, M. A., Washburn, J. J., & Becker-Weidman, E. (2007). Depression and suicide. In F. M. Dattilio, & A. Freeman (Eds.), *Cognitive –behavioral strategies in crisis intervention* (3rd ed.) (pp. 25-67). New York: Guilford Press.
- Revicki, D. A., Siddique, J., Chung, J. Y., Green, B. L., Krupnick, J., et al. (2005). Cost-effectiveness of evidence-based pharmacotherapy or cognitive-behavior therapy compared with community referral for predominately low-income minority women. *Archive of General Psychiatry*, 62, 868-875.
- Ritsher, J. B., Struening, E. L., Hellman, F., & Guardino, M. (2002). Internal validity of anxiety disorder screening instrument across five ethnic groups. *Psychiatry Research*, 111, 199-213.

- Rohde, P., Silva, S. G., Tonev, S. T., Kennard, B. D., Vitiello, B., Kratochvil, C. J., et al. (2008). Achievement and maintenance of sustained improvement during the treatment of adolescents with depression: Study continuation and maintenance therapy. *Archives of General Psychiatry*, *65*, 447-455.
- Rosello, J., & Bernal, G. (1996). Adapting cognitive-behavioral and interpersonal Treatments for depressed Puerto Rican adolescents: Two case studies. *Interamerican Journal of Psychology*, *27*, 163-180.
- Rosello, J., & Bernal, G. (1999). The efficacy of cognitive-behavioral and interpersonal Treatments for depression in Puerto Rican adolescents. *Journal of Consulting and Clinical Psychology*, *67*, 734-745.
- Roth A., & Fonagy, P. (2005). *What works for whom: A critical review of psychotherapy research* (2nd ed.). London: Guilford Press.
- Rupp, A., Gause, E., & Regier, D. (1998). Research policy implications of cost-of-illness studies for mental disorders. *British Journal of Psychiatry*, *36*, 19-25.
- Santiago-Rivera, Azara. (2003). Latinos values and family transitions: Practical considerations for counseling. *Counseling and Human Development*, *35*, 1-12.
- Santiago-Rivera, A. L., Arredondo, P., & Gallardo-Cooper, M. (2002). *Counseling Latinos and la familia: A practical guide*. Thousand Oaks, CA: Sage.
- Scott, J. (1992). Chronic depression. Can cognitive therapy succeed when other treatment fail? *Behavioral Psychotherapy*, *20*, 25-34.
- Schraufhagel, T., Wagner, A., & Byrne, R. (2006). Treating minority patients with depression and anxiety: What does the evidence say? *General Hospital*, *28*, 27-36.

- Seddon, K. H. (2003). Translations of Epictetus on the Internet. Retrieved March 30, 2008, from <http://www.btinternet.com/~k.h.s/epictetustranslations.htm>
- Seddon, K. H. (2006). Epictetus. *The Internet Encyclopedia of Philosophy*. Retrieved March 22, 2008, from <http://www.iep.utm.edu/e/epictetu.htm>
- Seligman, M. E. (1991). *Learned optimism*. New York: Alfred A. Knopf.
- Seligman, M. E. (1995). The effectiveness of psychotherapy. The Consumer Reports study. *American Psychologist*, *50*, 965–974.
- Sleath, B., Rubin, R. H., & Huston, S. A. (2003). Hispanic ethnicity, physician-patient communication and antidepressant adherence. *Comprehensive Psychiatry*, *44*, 198-204.
- Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: Techniques and procedures for developing grounded theory*. (2nd ed.). Thousand Oaks, CA: Sage Publications, Inc.
- Strupp, H. H., & Anderson, T. (1997). On the limitations of therapy manuals. *Clinical Psychology: Science and Practice*, *4*, 76-82.
- Sue, D. W. (2001). Multidimensional facets of cultural competence. *Counseling Psychologist*, *29*, 790-821.
- Sue, D. W., & Sue, D. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: John Wiley & Sons.
- Sue, D. W., & Sue, D. (2003). *Counseling the culturally diverse: Theory and practice* (4th ed.). New York: John Wiley & Sons.
- Sue, S. (1998). In search of cultural competency in psychotherapy and counseling. *American Psychologist*, *53*, 440-448.

- Sue, S. (2003). In defense of cultural competency in psychotherapy and treatment. *American Psychologist, 58*, 964-970.
- Sue, S., & Chu, J. Y. (2003). The mental health of Ethnic minority groups: Challenges posed by the Supplement to the Surgeon General's Report on Mental Health. *Culture, Medicine, and Psychiatry, 27*, 447-465.
- Suinn, R. M. (2003). Answering questions regarding the future directions in behavior therapy. *The Behavior Therapist, 26*, 282-284.
- Torres, L., & Rollock, D. (2004). Acculturative distress among Hispanics: The role of acculturation, coping, and intercultural competence. *Journal of Multicultural Counseling and Development, 32*, 155-167.
- Torres, L., & Rollock, D. (2007). Acculturation and depression among Hispanics: The moderating effect of intercultural competence. *Cultural Diversity and Ethnic Minority Psychology, 13*, 10-17.
- Trimble, J. E., (2003). Introduction: Social change and acculturation. In K. M. Chun, P. B. Organista, & G. Marin (Eds.), *Acculturation: Advances in theory, measurement, and applied research* (pp. 3-13). Washington DC: American Psychological Association.
- Tyler, F. B., Brome, D. R., & Williams, J. E. (1991). *Ethnic, validity, ecology, and psychotherapy: A psychological competence model*. New York: Plenum Press.
- Unutzer, J., Katon, W. J., Simon, G., Walker, E. A., Grembowski, D., & Patrick, D. (1996). Depression, quality of life, and use of health services in primary care Patients over 65: A 4-year prospective study. *Psychosomatics, 37*, 35.

- U.S. Census Bureau (2003). *Projections of resident population by race, Hispanic origin, and nativity: 2025-2050*. Hyattsville, MD: Author
- U.S. Census Bureau (2007). *Press Releases: Population and race*. Retrieved May 19, 2007, from <http://www.census.gov/Press-Release/www/releases/archives/population/010048.html>
- U. S. Department of Health and Human Services. (1999). *Mental health: a report of the Surgeon General – executive summary*. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Mental Health.
- U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. (1999). *Mental health: a report of the Surgeon General*. Rockville, MD: Author
- U. S. Department of Health & Human Services (2001). *Mental health: Culture, race, and Ethnicity. A supplement to mental health: A report of the Surgeon General*. Retrieved September 17, 2008, from <http://www.surgeongeneral.gov/library/mentalhealth/cre/>
- U. S. Department of Health & Human Services (2007). *Reports and Publications*. Office of the Surgeon General. Retrieved July 11, 2007, from <http://www.surgeongeneral.gov/library/reports.htm>
- Vega, W. A., Kolody, B., Aguilar-Gaxiola, S., & Catalano, R. (1999). Gaps in services utilization by Mexican Americans with mental health problems. *American Journal of Psychiatry*, 156, 928-934.
- Vega, W. A., & Lopez, S. R. (2001). Priority issues in Latino mental health services research. *Mental Health Services Research*, 3, 189-200.

- Vega, W. A., & Rumbaut, R. G. (1991). Ethnic minorities and mental health. *Annual Review of Sociology, 17*, 351-383.
- Vega, W. A., Sribney, W. M., Aguilar-Gaxiola, S., & Kolody, B. (2004). 12-month Prevalence of DSM-III psychiatric disorders among Mexican Americans: nativity, social assimilation, and age determinants. *Journal of Nervous and Mental Disease, 192*, 532-541.
- Voss Horrell, S. C. (2008). Effectiveness of cognitive-behavioral therapy with adult ethnic minority clients: A review. *Professional Psychology, Research and Practice, 39*, 160-168.
- Wang, P. S., Berglund, P., & Kessler, R. C. (2000). Recent care of common mental disorders in the United States: prevalence and conformance with evidence-based recommendations. *Journal of General Internal Medicine, 15*, 284-292.
- Wearing, V. R., & Weisz, J. R. (2002). Community clinic treatment of depressed youth: Benchmarking usual care against CBT clinical trials. *Journal of Consulting and Clinical Psychology, 70*, 299-310.
- Weingartner, K., Robison, J., Fogel, D., & Gruman, C. (2002). Depression and substance use in a middle aged and older Puerto Rican population. *Journal of Cross-Cultural Gerontology, 17*, 173-193.
- White, J. R. (2000). Depression. In J. R. White & A. Freeman (Eds.), *Cognitive-behavioral group therapy: For specific problems and populations*, (pp. 29-61). Washington, DC: American Psychological Association.
- World Health Organization (2001). *The World Health Organization report 2001: Mental health: New understanding, new hope*. Geneva: Author.

World Health Organization (2004). *The World Health Report 2004: Changing history*.

Annex Table 3: Burden of disease in DAYLs by cause, sex, and mortality stratum in WHO regions, estimates for 2002. Geneva: Author.

Zea, M. C., Asner-Self, K. K., Birman, D., & Buki, L. P. (2003). The abbreviated Multidimensional Acculturation Scale: Empirical validation with two Latino/Latina samples. *Cultural Diversity & Ethnic Minority Psychology, 9*, 107-126.

CHAPTER SEVEN

Appendices

Appendix A

Demographic Information

1. What is your Degree? _____
2. What is your Gender?
Male _____ Female _____
3. What is the range of your age?
Less than 30 _____ 30-39 _____ 40-49 _____ 50-59 _____
60-69 _____ 70-79 _____ 80 or more _____
4. Where were you born? _____
5. What is your nationality/country of origin? _____
6. What is your race? (select one or more of the categories listed)
Alaskan _____ African-American or Black _____ American Indian _____
Asian _____ Caucasian / White _____ Native Hawaiian _____
Other Pacific Islander _____ Other Race _____
7. What is your ethnicity?
Hispanic or Latino (a) _____ Neither Hispanic nor Latino (a) _____
8. How do you identify yourself?
Hispanic _____ Latino (a) _____ Both _____ Neither _____
9. What is your first language? _____
10. Do you Read _____ Speak _____ Write _____ the English language?
11. How do you describe your level of proficiency in the English language?
Read: (beginner) _____ (intermediate) _____ (fluent/advanced) _____
Write: (beginner) _____ (intermediate) _____ (fluent/advanced) _____
Speak: (beginner) _____ (intermediate) _____ (fluent/advanced) _____
12. Do you Read _____ Speak _____ Write _____ the Spanish language?

13. How do you describe your level of proficiency in the Spanish language?

Read: (beginner) _____ (intermediate) _____ (fluent/advanced) _____

Write: (beginner) _____ (intermediate) _____ (fluent/advanced) _____

Speak: (beginner) _____ (intermediate) _____ (fluent/advanced) _____

14. What is your language of preference?

English _____ Spanish _____ Both _____

15. What language do you primarily use when providing mental health services to Hispanic/Latino clients?

More Spanish _____ More English _____ Both _____

Why? _____

16. Where do you live (town and State)?

17. What is the geographic region where you practice?

Rural _____ Suburban _____ Urban _____

18. What is your Therapeutic Orientation (choose one):

Cognitive-Behavioral _____ Eclectic _____ Family Therapy _____

Gestalt _____ Psychoanalytic _____ Psychodynamic _____

Humanistic _____ Existential _____ Feminist _____

19. Number of years as a therapist: _____

20. Number of years working with Hispanic/Latino clients: _____

21. What is the average number of Hispanic/Latino clients you work with on a monthly basis? _____ Do you see more women or men? _____

22. What are the ranges of age of the clients you see? _____

23. What country of origin are most of your Hispanic/Latino clients from?

Cuba _____ Puerto Rico _____ Republica Dominicana _____

México _____ Nicaragua _____ Costa Rica _____ Guatemala _____

El Salvador _____ Honduras _____ Panamá _____ Venezuela _____

Colombia ____ Ecuador ____ Perú ____ Bolivia ____

Chile ____ Argentina ____ Uruguay ____ Paraguay ____

24. What are the problems you see your Hispanic/Latino clients for?

Depression ____ Anger Management ____ Anxiety ____

Post-Traumatic Stress ____ Alcohol/Substance Abuse ____

Adjustment Disorder ____ Marital/Family Problems ____

Acculturation Issues (explain) _____

Other (specify) _____

25. How do you rate the average length of time Hispanic/Latino clients remain in treatment?

0-3 months ____ 6-9months ____ 12-18 months ____

3-6 months ____ 9-12 months ____ more than 18 months ____

26. How do you describe your level of multicultural competence?

Personal Experience (explain) _____

Professional Experience (explain) _____

Formal Training (explain) _____

Appendix B

Semi-Structured Interview for Bilingual (Spanish-English/English-Spanish) Mental Health Providers

Instructions to Participant: I want to begin by thanking you for participating in this interview which, as you already know, seeks your comments on the vignette and recommendations I provided to you earlier for your review. I developed those recommendations to make the client's manual "*Guia para Miembros del Grupo*" (Group Member's Guidebook) culturally sensitive to Hispanic/Latino males with depression. As you know, this study focuses on the adaptation of the first module of the manual, "Thoughts and Your Mood," which includes treatment sessions 1 thru 4. I am going to ask you a few open-ended questions. For each of the 4 sessions, you will be asked to comment on:

- The instructions provided for both the group leader (therapist) and the group members (clients)
- The vignette and how it is used in treatment, whether it accomplishes the goal of addressing cultural values and beliefs relevant to Hispanic/ Latino clients
- The questions provided for the group members (clients) to emphasize treatment issues and help them practice what they learned during the session

I will ask you 7 open-ended questions to get your comments on the recommendations I provided for each of the 4 therapy sessions. Answering the open questions should take about 1 hour. It is my hope that the information you provide during this interview will help refine my recommendations for culturally sensitive Group CBT with Hispanic/Latino males with depression. Please provide as much information as possible because your answers will give a strong basis for delivering culturally sensitive treatment to these clients. Feel free to ask questions if you are not sure what I am asking. You are allowed to decide not to answer any questions, for any reason. However, with your permission, I would like to be able to ask why you did not want to answer the question. When finishing answering the questions, you may add anything that you feel is important and that was not asked, but which you feel could add to what has been discussed.

Remember that you may answer these interview questions via e-mail, over the phone, or in person (if in Mid-Atlantic Region), whichever is more convenient for you. Just let me know what your preference is. Here are the questions you will be asked to answer for each of the 4 therapy sessions (Module I):

Open-Ended Questions

1. With regard to the instructions provided for Session #____:
 - c. Do you think the instructions provided for the Group Leader (therapist) are sufficient? Please explain.
 - d. Do you think the instructions provided for Group Members (clients) are sufficient? Please explain.
2. Do you think the questions provided to Group Members (clients) are sufficient? Please explain.
3. In the vignette about Fernando, did I address cultural values/beliefs relevant to Hispanics/Latinos? _____ Please specify:
 - a. What was more helpful
 - b. What was less helpful
4. What cultural values and/or beliefs you feel that needed to be addressed in the session, but were not?
5. Overall, in a scale from 0 (none) to 10 (most) please rate to what degree my suggestions addressed Hispanics/Latinos' cultural values and beliefs? _____
6. Is there any further recommendation you would add to make the treatment experience more culturally sensitive to Hispanic/Latino clients?
7. Is there any other comment you wish to add?

Appendix C1

**Recommendations for Adapting Treatment Manual
Module I – Session 1**

MODULE I: “Thoughts and Your Mood” [*“Los Pensamientos y su Estado de Animo”*]

SESSION 1: “Your Thoughts and Mood are connected” [*“Existe una conexión entre sus Pensamientos y su Estado de Animo”*]

Purpose of Session 1

As per manual guidelines, in this session group members introduce themselves and, as the group session progresses, they talk about their experiences with depression. Group members learn about depression and Cognitive-Behavioral Therapy (CBT) and the connection between thoughts and mood. They learn that identifying and managing their thoughts can help them feel better. They also begin identifying their harmful thoughts, as well as their helpful thoughts.

Instructions to Group Leader (therapist)

- Implement each topic of Session 1 (e.g., introductions, what is depression, the connection between thoughts and your mood) according to the manual guidelines and tips
- Allow extra time for Session 1, as it may take longer than the 2 recommended hours in the manual due to group members narrating their immigration journey
- It is important that during the “Introductions,” you give group members the opportunity to tell their own immigration journey voluntarily
- Follow the presentation of each topic in Session 1 with the vignette on Fernando, as indicated
- Present the first vignette after completing section on “Introductions” and before starting section on “what is Depression”
- Follow the presentation of the vignette on Fernando with questions to group members as indicated and take time to discuss group members’ answers, helping them practice what was addressed in the therapy session
- Copy of the vignette may be provided to group members so they can read it along with the group leader
- End Session 1 according to manual guidelines and get group members’ feedback

TOPIC: Introductions**Group Leader' Instructions to Group Members**

“Today, I want to start by telling you the story of Fernando. We are going to be talking about Fernando throughout the modules and sessions. Listen to what I tell you happened to Fernando and imagine you going through the same experiences. I will later ask you about how you think and feel about Fernando. This is his story.”

Vignette to address Group Members' Introductions and Immigration Journey

Fernando is an adult male born in a Latino-American country, who immigrated to the United States (U.S.) six years ago. He is the only son and oldest of four children. His father, a taxi driver, died in a car accident seven years ago. Fernando was in his early twenties and was married at the time of his father's death. This was a tragedy that affected all family members tremendously but mostly Fernando's mother, who suddenly became a young widow caring for her younger daughters. In Fernando's country, life insurance, widow's benefits, or social security's income is not the norm. Following his father's death, Fernando began taking care of his mother and his three younger sisters in addition to providing for his wife, Ana Maria, and his then one-year old daughter. Fernando did not have time to mourn his father's death, as he had to assume his paternal role right away. He remembered what his father always told him while growing up: “when I am not here, you are the man of the house; you are in charge.” Both Fernando's wife and his mother assumed homemaking responsibilities while he provided for the family. Fernando had attended college for three years to become an economist, but did not complete his studies nor did he earn his degree. Instead, he began working in a bank, as a teller, after getting married. When Fernando's father died, his parents' *compadres* (sisters' godparents), relatives, and close friends offered financial help to the family, but Fernando insisted that he could manage their financial needs by working overtime, and getting a second job, which he did. These arrangements did not last too long and the family financial needs increased. Fernando became worried that he could not support his family (e.g., mother, wife, daughter, three sisters). He did not want his wife to work. Fernando believed that he “was the head of the family” and it was his responsibility to provide for them. He also reminded his wife that their daughter needed her at home. Fernando began thinking about his relatives' advice that he joined his cousins in the U.S.,

where he “would have better job opportunities, make more money, and easily provide for his family.” His cousins in the U.S. offered him a place to stay and contacts to start working right away. Fernando was hesitant to make the journey because of his limited knowledge of the English language, not having a degree, and having to leave his family behind. His first language was Spanish. After some consideration, Fernando and his wife agreed that he emigrated to the U.S. They thought it was worthy to try for “a better future.” They decided that Fernando would come first, alone, get established, and later send for the rest of the family to join him. Fernando promised to start working immediately and send money to his native country to support his mother, wife, daughter, and sisters. Although Fernando’s mother was reluctant to the idea of seeing her son go, she gave her blessing to him and hoped to see him again soon. It was very difficult for Fernando to leave his family behind, but comforted himself by thinking: “It is for a better future for my family.” Fernando made arrangements with his aunts and cousins in the U.S. so that they would be there to help him upon his arrival.

When in the U.S., Fernando went to live with his relatives at their home and began working as a mechanic in a factory where his cousins recommended him for the job. The first months in the U.S. were very stressful for Fernando. Everything seemed fast and overwhelming to him. He had so much to learn and adjust to (e.g., new country, new culture, new people, new food, new language, and new rhythm of life). Fernando kept busy by working two jobs and submerged himself in activities he thought would be helpful to him (e.g., local church, English as second language classes, Hispanic community). Despite all this, Fernando experienced sadness and loneliness because he missed his family in his native country. His wife sent family pictures to Fernando on a regular basis, which he found comforting. However, keeping in touch with them by letters and phone calls was not enough. He wanted to be with them.

Fernando established a routine that included working two jobs during the week, watching and playing soccer with his cousins and their friends on Saturdays, and going to church on Sundays. Fernando was able to send money to his native country regularly and felt good about it. Thanks to him, the family was able to live comfortably and began building a new house in their country. Fernando’s sisters were attending private school, because of his support. His mother never remarried and still depended on his financial

support. The family praised Fernando’s sacrifice and efforts, and looked forward to reunite with him.

Group Leader’s Questions to Group Members

- Can you imagine yourself experiencing a similar situation to that described in Fernando’s story?
- Do you know a family member or friend who has experienced a similar situation?
- Who would like to share a personal story?

[Group leader is to stop and discuss group members’ answers]

TOPIC: What is Depression?

Instructions to Group Leader

- Start with instructions to group members, as indicated
- Refer to manual and complete section on depression as per manual guidelines
- Follow with vignette and questions, as indicated

Group Leader’ Instructions to Group Members

“We will review parts of Fernando’s story again, as we move forward throughout the sessions and modules and you have the chance to apply what we discussed in the session. Now, let’s talk about what is depression.”

[Group leader is to refer to manual and complete this section – page 6 thru 7]

Vignette to Recognize Depression

“Remember Fernando’s story? Listen to what I tell you happened to Fernando and imagine you going through the same experiences. I will later ask you about how you think and feel about Fernando.”

After four years in the U.S., Fernando had saved enough money to get a place of his own and bring his family to live with him. Now, his daughter was 5 years old now, and Fernando feared that she would not recognize him anymore. Fernando’s wife was eager to join him, but his mother decided that she and his sisters would stay in their native country. Although disappointed, Fernando agreed to his mother’s request and promised to keep supporting her and his sisters. Everything appeared to be going well in Fernando’s life when he reunited with his wife and daughter. He was very “happy.” Fernando kept working two jobs while his wife stayed home taking care of the house and

looking after their daughter who was in school. Fernando's wife easily integrated with their relatives in the U.S. and organized Sunday's family luncheons, which were a family tradition. The family was very active in their local church and the Hispanic community. One year later, Fernando and his wife had their second child, a son. They asked Fernando's cousin, Lorenzo, and his wife, Aurora, to be the "*padrinos*" (godparents). Soon after, Fernando was promoted to a supervisor position at work and decided to quit his second job to be able to spend more time with his family. Even though Fernando and his wife sometimes became home sick and wished to be in their native country, life seemed to be "good" for them in the U.S., and Fernando was able to keep providing for his mother and his sisters in their native country. Suddenly, one day, Fernando received bad news at work; he was laid off. He could not believe it, because he had recently been promoted. He always saw himself as a "good worker" and wondered what he "had done wrong." He blamed himself for not having done a better job and for quitting his second job. Fernando became extremely worried about not being able to provide for his family. In the days that followed, Fernando began acting different at home. His wife noted that he was irritable and yelling at the children for no reason. He was also argumentative and rejected his wife attempts to comfort him. Fernando stayed in bed complaining of back pain and headaches. Sometimes he did not get up from bed, did not eat, and did not bathe. At night, he was not able to sleep well. All these were unusual behaviors for Fernando and his wife was extremely worried. She asked Fernando to go to see the doctor and find out what was wrong with him, but Fernando refused. Now they were arguing a lot and their marriage and family life started to tremble. Two months passed and Fernando's behavioral changes did not improve. He seemed to be getting worse.

Group Leader's Questions to Group Members

- Can you relate to Fernando? Do you know somebody who has similar experiences like Fernando?
- How depression is like for you? What was happening in your life when you got depressed?
- What do you think is happening to Fernando?
- What is depression like for Fernando?
- What are Fernando's symptoms of depression?

- What do you think is causing Fernando's depression?
- What was happening in Fernando's life when he became depressed?
- What Can Fernando do? What would you recommend him to do?
- What do you think is the reason why Fernando is reluctant to go to the doctor and get help?

[Group leader is to stop and discuss group members' answers]

TOPIC: The Connection between Thoughts and Mood

Instructions to Group Leader

- Start with instructions to group members, as indicated
- Refer to manual and complete section on CBT as per manual guidelines
- Follow with vignette and questions, as indicated. Must discuss group members' answers
- End session according to manual guidelines, which include key messages, practice, tracking thoughts, quick mood scale, and group members' feedback

Group Leader' Instructions to Group Members

“Now, let's talk about “The Connection between Thoughts and Mood.”

[Complete topic per manual outline].

Vignette to Recognize the Connection between Thoughts and Mood

“Remember Fernando's story? Listen to what I tell you happened to Fernando and imagine you going through the same experiences. I will later ask you about how you think and feel about Fernando.”

After losing his job, Fernando supported himself and his family using his savings and receiving assistance from relatives and friends in the U.S. They encouraged him to “hang in there” and “have faith.” His aunts reminded Fernando that “*Dios aprieta pero no ahoga*,” (God squeezes but he does not choke), and that “*Despues de la tormenta brilla el sol*” (After a storm, the sun shines). Fernando tried to be hopeful, but he could not stop feeling down and thinking “I have disappointed my family;” “I am a failure;” “I cannot do anything right.” He often felt like crying, but he remembered the saying “*los hombres no lloran*” (men do not cry) and contained himself. Fernando worried about his

mother and his sisters, who were in his native country and depended on him. He kept thinking: “I am not a man if I cannot provide for my family;” “I am worthless.”

Questions to Recognize the Connection between Thoughts and Mood

- What are some of Fernando’s “harmful” thoughts?
- How Fernando’s “harmful” thoughts make him feel and act?
- What do you think are Fernando’s “harmful” thoughts that bring his mood down?
- Does Fernando have any “helpful” thoughts at the present time?
- How can Fernando develop “helpful” thoughts?
- Fernando cannot change the upsetting events in his life. Do you think he can change the way he thinks? How can he do that?
 - What does the saying “Everything is according to the color of the glass with which is viewed” (“*Todo es según el color del cristal con que se mira*”) mean? How this saying applies to Fernando?
 - What does the saying “God helps those who help themselves” (“*Dios ayuda a esos que se ayudan a sí mismo*”) mean? How this saying applies to Fernando?
 - What does the saying “After a storm, the sun shines” (“*Despues de la tormenta brilla el sol*”) mean? How this saying applies to Fernando?

[Group leader is to stop and discuss group members’ answers]

Questions to Solicit Group Members’ Feedback

- What did you learn from Fernando’s story?
- What was most helpful?
- What was least helpful?

[End Session 1 according to manual guidelines - page 23 thru 31]

Appendix C2

Recommendations for Adapting Manual Module I – Session 2

MODULE I: “Thoughts and Your Mood” [*“Los Pensamientos y su Estado de Animo”*]

SESSION 2: “Identifying Harmful Thoughts and Helpful Thoughts” [*“Como Identificar Pensamientos Dañinos y Pensamientos Utiles”*]

Purpose of Session 2

As per manual guidelines, in this session group members learn to recognize how “harmful” thoughts can bring their mood down and how “helpful” thoughts can improve their mood. Group members learn to understand some common habits of harmful thinking, and how changing those common habits of harmful thinking can improve their mood.

Instructions to Group Leader (therapist)

- Implement each topic of Session 2 according to the manual guidelines and tips
- Follow each topic in Session 2 with a section of the vignette on Fernando
- Copy of the vignette may be provided to group members so they can read it along with the group leader
- Help group members practice what they learned in the session by applying it to Fernando’s situation. Ask questions, as indicated.
- End Session 2 according to manual guidelines, which include key messages, practice, tracking thoughts, quick mood scale, and group members’ feedback

TOPIC: How to Identify Harmful Thoughts and Helpful Thoughts

Group Leader’ Instructions to Group Members

“Let’s review the connection between thoughts and mood, and how thoughts can affect the way someone feels and behave, in a harmful or helpful manner. I will continue telling you the story about Fernando and will ask you for some ideas on how he can start noticing his harmful thoughts and replace them with helpful thoughts. Listen to what I tell you happened to Fernando and imagine you going through the same experiences. I will later ask you about how you think and feel about Fernando.”

Vignette

Things got worse when Fernando began looking for another job. He applied to several jobs, but nobody called him for an interview. He began saying, “I will never get another job;” “I am dumb.” His desperation intensified when he received news that his mother was sick. He believed that “it was his fault” and blamed himself for hurting his mother. He also thought that “God had forgotten” him or “was punishing” him for something. Fernando stopped doing all the things he used to do and enjoyed before (e.g., playing soccer, going to church on Sundays), and despite his wife’s efforts to get him participate in family events, he refused. He wanted to be alone.

Group Leader’s Questions to Group Members (chaining activity)

- Identify the event in Fernando’s life. What happened recently to Fernando?
- What thought Fernando has that brings his mood down just a little bit?
- What thought can make Fernando’s mood worse?
- What thought brings Fernando’s mood to the lowest point?
- Can you give an example of a thought that can bring Fernando’s mood up a little?
- Can you give an example of a thought can make Fernando’s mood better?
- What thought would make Fernando feel very happy?
- See the connection between Fernando’s thoughts and his mood?
- How Fernando’s thoughts affect his feelings and his behavior?
- Can Fernando choose his thoughts?

[Group leader is to stop and discuss group members’ answers]

[Next, refer to manual and continue according to guidelines - page 39 thru 43]

TOPIC: Harmful Thoughts are not Accurate, Complete, and Balanced***Group Leader’ Instructions to Group Members***

“Let’s review why harmful thoughts are not accurate or true, not complete, and not balanced. We will practice how to identify the different categories of harmful thoughts. I will tell you more about Fernando. Listen to what I tell you happened to Fernando and imagine you going through the same experiences. I will later ask you about how you think and feel about Fernando.”

Vignette

When Fernando lost his job, his wife tried to comfort him and suggested that he talked to his boss and asked what happened. Fernando did not like the idea of confronting his boss or complaining. He kept blaming himself for losing his job and questioned his abilities. He stated, “All is my fault;” “I am not qualified for the job; that is why they let me go.” Fernando told his wife: “I know you are disappointed with me;” “What kind of man am I that I cannot provide for my family.” Fernando’s wife reminded him about the times he was able to provide for the family and help his mother in their native country, but he dismissed those times. Fernando stopped looking for a job and was always in a “bad mood.” He kept saying “what is the purpose of looking?” “Nobody is going to hire me.” His wife decided to confide in her *comadre* Aurora. She told her what was happening with Fernando at home and asked for her advice. Aurora then asked her husband Lorenzo to talk to Fernando. When approached by his *compadre* Lorenzo, Fernando felt embarrassed for all that was happening. He told Lorenzo: “you probably think I am a loser;” “everything is going wrong in my life;” “I will never get out of this situation.”

Group Leader’s Questions to Group Members

- What is an example of Fernando’s thought of “pessimism”?
- What is Fernando’s thought of “all-or-nothing”?
- What is Fernando’s thought of “mind reading”?
- What is Fernando’s thought of “exaggerating”?
- What is Fernando’s thought of “negative filter” (ignoring the positive)?
- What is Fernando’s thought of “labeling”?
- Does Fernando give himself credit for his efforts? How come?
- What is Fernando’s thought of “Overgeneralization”?
- What is Fernando’s thought of “negative fortune telling”?

[Group leader is to stop and discuss group members’ answers]

Questions to Solicit Group Members' Feedback

- What did you learn from Fernando's story?
- What was most helpful?
- What was least helpful?

[End Session 2 according to manual guidelines - page 44 thru52]

Appendix C3

Recommendations for Adapting Manual Module I – Session 3

MODULE I: “Thoughts and Your Mood” [*“Los Pensamientos y su Estado de Animo”*]

SESSION 3: “Talking Back to Your Harmful Thoughts” [*“Contradiciendo sus Pensamientos Daninos”*]

Purpose of Session 3

As per manual guidelines, after learning to identify the different categories of their harmful thoughts, in session 3 group members start learning to control their harmful thoughts to improve their mood. They learn skills on how to “contradict” (challenge) their harmful thoughts. The emphasis on the relationship between harmful thoughts and mood continues.

Instructions to Group Leader (therapist)

- Implement each topic of Session 3 according to the manual guidelines and tips
- Follow each topic in Session 3 with a section of the vignette on Fernando, as indicated
- Copy of the vignette may be provided to group members so they can read it along with the group leader
- Help group members practice what they learned in the session by applying it to Fernando’s situation. Ask questions, as indicated.
- End Session 3 according to manual guidelines and get group members’ feedback

TOPIC: Talking Back to Your Harmful Thoughts

Group Leader’ Instructions to Group Members

“Now, we will review how you can “contradict” or “talk back to” your harmful thoughts to replace them with helpful thoughts to improve your mood. Remember Fernando story? Listen to what I tell you happened to Fernando and imagine you going through the same experiences. I will later ask you about how you think and feel about Fernando.”

Vignette

When approached by his *compadre* Lorenzo, Fernando told him: “you probably think I am a loser;” “Everything is going wrong in my life;” “I will never get out of this situation.” He also said that he did not apply for other jobs, because everybody rejected him. He added: “No matter what I do, nobody will hire me again;” “I am useless.” *Compadre* Lorenzo reminded Fernando about the prior jobs he was able to get and perform, but Fernando answered: “Yes, but they were not great jobs.” Lorenzo asked Fernando not to give up. He suggested contacting people in their church to ask for help, but Fernando did not want others to know about his situation. He felt embarrassed and did not want people in church to think he “was a loser.” *Compadre* Lorenzo was able to bring to Fernando’s attention that his problems and his behaviors were affecting his relationship with his wife and their children. He told Fernando “Your family needs you;” “You must get well for them.” Lorenzo advised Fernando to see the doctor and offered to schedule an appointment on his behalf, to which Fernando agreed. The family doctor found that Fernando was physically healthy and that his reported symptoms (e.g., headaches, back pain, insomnia, hypersomnia, poor appetite, lack of energy, irritability, mood swings, withdraw, hopelessness, loss of interest in favorite activities, etc.) were not caused by a medical condition. The doctor explained to Fernando that he might be suffering with **depression** and offered to refer him to a mental health provider for further assessment and treatment. Fernando immediately thought: “This is worst than I thought!” “I am crazy!” “The doctor is going to put me away?” “They will drug me.”

Group Leader’s Questions to Group Members

- What evidence/proof Fernando has that his thought of “I am useless” is true?
- What evidence/proof Fernando has that his thought of “I am useless” is false?
- How can Fernando check whether his thought that he is a “useless” is accurate/true?
- Fernando thinks that “Nobody will hire him again.” How real/accurate is that thought? How come?
- What Fernando can do to be sure that his thought of “I will never get out of this situation” is accurate/true?

- What evidence Fernando has that he is “crazy” and that the doctor will “put him away”?
- Are these kind thoughts “harmful” or “helpful” to Fernando?
- How can Fernando replace his thought that “health providers will drug him” with a helpful thought?

[Group leader is to stop and discuss group members’ answers]

Questions to Solicit Group Members’ Feedback

- What did you learn from Fernando’s story?
- What was most helpful?
- What was least helpful?

[End Session 3 according to manual guidelines - page 68 thru 71]

Appendix C4

Recommendations for Adapting Manual Module I – Session 4

MODULE I: “Thoughts and Your Mood” [*“Los Pensamientos y su Estado de Animo”*]

SESSION 4: “How to Have More Helpful Thoughts to Improve Your Mood” [*“Como Tener Mas Pensamientos Utiles para Mejorar Su Estado de Animo”*]

Purpose of Session 4

As per manual guidelines, in this session group members learn strategies to have more “helpful thoughts” and understand how helpful thoughts can help them improve their mood and have the life they want.”

Instructions to Group Leader (therapist)

- Implement each topic of Session 4 according to the manual guidelines and tips
- Follow each topic in Session 4 with a section of the vignette on Fernando, as indicated
- Copy of the vignette may be provided to group members so they can read it along with the group leader
- Help group members practice what they learned in the session by applying it to Fernando’s situation. Ask questions, as indicated.
- End Session 4 according to manual guidelines and get group members’ feedback

TOPIC: How to Have More Helpful Thoughts & Balancing Thoughts with “Yes, but...”

Group Leader’ Instructions to Group Members

“Now, let’s practice how to have more helpful thoughts. Remember Fernando’s story? Do you remember what he has gone through? I will remind you about some of his experiences and I will also tell you about new things that happened to him. Listen to what I tell you about Fernando and imagine you going through the same experiences. I will later ask you about how you think and feel about Fernando.”

Vignette

As you may recall, after losing his job, Fernando tried to be hopeful, but he could not stop feeling down and thinking that he “was a failure” and that he “could not do anything right.” Fernando did not recognize the good things he had done for his family in the past, providing for them. He thought he “had failed them” and that they “were disappointed with him.” Fernando questioned what kind of man he was that could not provide for his family. According to Fernando, he “was worthless” because he had no job and could not provide for his family. He was really feeling down. When he went to see the family doctor, Fernando was told that he appeared to be depressed and the doctor explained all about it, such as, how treatable depression was, how psychotherapy would be helpful, and that he might not need to take antidepressants, but he had to see the mental health provider (“*profesional en salud mental*”). Fernando stated “I do not think the mental health provider can help me;” “I just need to be stronger and this will go away.” Fernando did not keep his appointment with the mental health provider, because he was afraid that the provider would send him to the “nuts’ house.” Fernando told his wife and his *compadre* Lorenzo that he wanted to solve his problems on his own. He remembered the saying, “*Los trapos sucios se lavan en casa*” (The dirty cloth is washed at home), and rejected the idea of having to tell his problems to a stranger. His wife insisted that Fernando give it a try and encouraged him to get help. When talking to his *compadre* Lorenzo, and the “*padrecito*” (priest) at his church, both of them exhorted Fernando to seek mental health care. They both told him about some people they knew who successfully received professional help for their emotional difficulties. The *padrecito* reminded Fernando “*Dios ayuda a esos que se ayudan a sí mismo*” (“God helps those who help themselves”). Fernando decided to get a new appointment and start treatment for his depression.

Group Leader’s Questions to Group Members

- Can you help Fernando complete the following sentences?
 - Yes, I lost my job, but..... (it does not mean I am a loser)
 - Yes, it may take me some time to find another job, but (it does not mean I will not find one)

- Yes, I cannot provide for my family right now, but.... (there are still many things I can do for my family)
- Yes, I am not working, but(it does not mean I am useless)
- Yes, these are difficult times, but..... (it does not mean it will always be this way)
- Yes, “the dirty cloth is washed at home, but..... (is “ok” to get help to wash it)
- How do you think Fernando would feel if he tells himself:
 - I am a good and responsible man. I have always worked hard to provide for my family and love ones
 - I have family and friends who love me and support me
 - My family still loves me and supports me, regardless if I am working or not
- How accurate is Fernando’s thought “I cannot do anything right”? What would you tell Fernando to contradict his thought?
- How can Fernando contradict his thought “I am worthless”?
- What other kind of “helpful” thoughts would you advise Fernando to tell himself to feel better?
- What kind of “harmful” thoughts you would advise Fernando *not* to tell himself?
- Can you relate to Fernando? What are some of your thoughts that bring your mood down?
- What are some “helpful” thoughts you can tell yourself to improve your depression?

[Group leader is to stop and discuss group members’ answers]

Questions to Solicit Group Members’ Feedback

- What did you learn from Fernando’s story?
- What was most helpful?
- What was least helpful?

[End Session 4 according to manual guidelines - page 81 thru 86]

Appendix D**Vignette
Male Character**

Fernando is an adult male born in a Latino-American country, who immigrated to the United States (U.S.) six years ago. He is the only son and oldest of four children. His father, a taxi driver, died in a car accident seven years ago. Fernando was in his early twenties and was married at the time of his father's death. This was a tragedy that affected all family members tremendously but mostly Fernando's mother, who suddenly became a young widow caring for her younger daughters. In Fernando's country, life insurance, widow's benefits, or social security's income is not the norm. Following his father's death, Fernando began taking care of his mother and his three younger sisters in addition to providing for his wife, Ana Maria, and his then one-year old daughter. Fernando did not have time to mourn his father's death, as he had to assume his paternal role right away. He remembered what his father always told him while growing up: "when I am not here, you are the man of the house; you are in charge." Both Fernando's wife and his mother assumed homemaking responsibilities while he provided for the family. Fernando had attended college for three years to become an economist, but did not complete his studies nor did he earn his degree. Instead, he began working in a bank, as a teller, after getting married.

When Fernando's father died, his parents' *compadres* (sisters' godparents), relatives, and close friends offered financial help to the family, but Fernando insisted that he could manage their financial needs by working overtime, and getting a second job, which he did. These arrangements did not last too long and the family financial needs increased. Fernando became worried that he could not support his family (e.g., mother, wife, daughter, three sisters). He did not want his wife to work. Fernando believed that he "was the head of the family" and it was his responsibility to provide for them. He also reminded his wife that their daughter needed her at home. Fernando began thinking about his relatives' advice that he joined his cousins in the U.S., where he "would have better job opportunities, make more money, and easily provide for his family." His cousins in the U.S. offered him a place to stay and contacts to start working right away. Fernando was hesitant to make the journey because of his limited knowledge of the

English language, not having a degree, and having to leave his family behind. Fernando's first language was Spanish. After some consideration, Fernando and his wife agreed that he emigrated to the U.S. They thought it was worth trying for "a better future." They decided that Fernando would come first, alone, get established, and later send for the rest of the family to join him. Fernando promised to start working immediately and send money to his native country to support his mother, wife, daughter, and sisters. Although Fernando's mother was reluctant to the idea of seeing her son go, she gave her blessing to him and hoped to see him again soon. It was very difficult for Fernando to leave his family behind, but comforted himself by thinking: "It is for a better future for my family." Fernando made arrangements with his aunts and cousins in the U.S. so that they would be there to help him upon his arrival.

When in the U.S., Fernando went to live with his relatives at their home and began working as a mechanic in a factory where his cousins recommended him for the job. The first months in the U.S. were very stressful for Fernando. Everything seemed fast and overwhelming to him. He had so much to learn and adjust to (e.g., new country, new culture, new people, new food, new language, and new rhythm of life). Fernando kept busy by working two jobs and submerged himself in activities he thought would be helpful to him (e.g., local church, English as second language classes, Hispanic community). Despite all this, Fernando experienced sadness and loneliness because he missed his family in his native country. His wife sent family pictures to Fernando on a regular basis, which he found comforting. However, keeping in touch with them by letters and phone calls was not enough. He wanted to be with them.

Fernando established a routine that included working two jobs during the week, watching and playing soccer with his cousins and their friends on Saturdays, and going to church on Sundays. Fernando was able to send money to his native country regularly and felt good about it. Thanks to him, the family was able to live comfortably and began building a new house in their country. Fernando's sisters were attending private school, because of his support. His mother never remarried and still depended on his financial support. The family praised Fernando's sacrifice and efforts, and looked forward to reunite with him.

After four years in the U.S., Fernando had saved enough money to get a place of his own and bring his family to live with him. Now, his daughter was 5 years old now. Fernando's wife was eager to join him, but his mother decided that she and Fernando's sisters would stay in their native country. Although disappointed, Fernando agreed to his mother's request and promised to keep supporting her and his sisters. Everything appeared to be going well in Fernando's life when he reunited with his wife and daughter. He was very "happy." Fernando kept working two jobs while his wife stayed home taking care of the house and looking after their daughter who was in school. Fernando's wife easily integrated with their relatives in the U.S. and organized Sunday's family luncheons, which were a family tradition. The family was very active in their local church and the Hispanic community. One year later, Fernando and his wife had their second child, a son. They asked Fernando's closest cousin, Lorenzo, and his wife, Aurora, to be the "*padrinos*" (godparents). Soon after, Fernando was promoted to a supervisor position at work and decided to quit his second job to be able to spend more time with his family. Even though Fernando and his wife sometimes became home sick and wished to be in their native country, life seemed to be "good" for them in the U.S., and Fernando was able to keep providing for his mother and his sisters in their native country. Suddenly, one day, Fernando received bad news at work; he was laid off. He could not believe it, because he had recently been promoted. He always saw himself as a "good worker" and wondered what he "had done wrong." Fernando blamed himself for not having done a better job and for quitting his second job. He became extremely worried about not being able to provide for his family. His wife tried to comfort him and suggested that he talked to his boss and asked what happened. Fernando did not like the idea of confronting his boss or complaining. He kept blaming himself for losing his job and questioned his abilities. He stated, "All is my fault;" "I am not qualified for the job; that is why they let me go."

In the days that followed, Fernando began acting different at home. His wife noted that he was irritable and yelling at the children for no reason. He was also argumentative and rejected his wife attempts to comfort him. Fernando stayed in bed complaining of back pain and headaches. Sometimes he did not get up from bed, did not eat, and did not bathe. At night, he was not able to sleep well. All these were unusual

behaviors for Fernando and his wife was extremely worried. She asked Fernando to go to see the doctor and find out what was wrong with him, but Fernando refused. Now they were arguing a lot and their marriage and family life started to tremble. Two months passed and Fernando's behavioral changes did not improve. He seemed to be getting worse. Things got worse when Fernando began looking for another job. He applied to several jobs, but nobody called him for an interview. He began saying, "I will never get another job;" "I am dumb."

When all this was happening, Fernando supported himself and his family using their savings and receiving assistance from relatives and friends in the U.S. They encouraged him to "hang in there" and "have faith." His aunts reminded him that "*Dios aprieta pero no ahoga*," (God squeezes but he does not choke), and that "*Despues de la tormenta, brilla el sol*" (After a storm, the sun shines). Fernando tried to be hopeful, but he could not stop feeling down and thinking "I have disappointed my family;" "I am a failure;" "I cannot do anything right." He often felt like crying, but he remembered the saying "*los hombres no lloran*" (men do not cry) and contained himself. Fernando worried about his mother and his sisters, who were in his native country and depended on him. He kept thinking: "I am not a man if I cannot provide for my family;" "I am worthless."

His desperation intensified when he received news that his mother was sick. He believed that it was "his fault" and blamed himself for hurting his mother. He also thought that God "had forgotten" him or "was punishing" him for something. Fernando stopped doing all the things he used to do and enjoyed before (e.g., playing soccer, going to church on Sundays), and despite his wife's efforts to get him participate in family events, he refused. He wanted to be alone. Fernando told his wife: "I know you are disappointed with me;" "What kind of man am I that I cannot provide for my family." Fernando's wife reminded him about the times he was able to provide for the family and help his mother in their native country, but he dismissed those times.

Fernando stopped looking for a job and was always in a "bad mood." He kept saying "what is the purpose of looking?" "Nobody is going to hire me." His wife decided to confide in her *comadre* Aurora. She told her about what was happening with Fernando at home and asked for her advice. Aurora then asked her husband Lorenzo to talk to

Fernando. When approached by his *compadre* Lorenzo, Fernando felt embarrassed for all that was happening. He told Lorenzo: “you probably think I am a loser;” “everything is going wrong in my life;” “I will never get out of this situation.” Fernando was able to share his feelings with his *compadre* Lorenzo and told him that he did not apply for other jobs, because everybody rejected him. He added: “No matter what I do; nobody will hire me again;” “I am useless.” *Compadre* Lorenzo reminded Fernando about the prior jobs he was able to get and perform, but Fernando answered: “Yes, but they were not great jobs.” Lorenzo asked Fernando not to give up. He suggested contacting people in their church to ask for help, but Fernando did not want others to know about his situation. He felt embarrassed and did not want people in church to think he “was a loser.” *Compadre* Lorenzo was able to bring to Fernando’s attention that his problems and his behaviors were affecting his relationship with his wife and their children. He told Fernando “Your family needs you;” “You must get well for them.” Lorenzo advised Fernando to see the doctor and offered to schedule an appointment on his behalf, to which Fernando agreed.

The family doctor found that Fernando was physically healthy and that his reported symptoms (e.g., headaches, back pain, insomnia, hypersomnia, poor appetite, lack of energy, irritability, mood swings, withdraw, hopelessness, loss of interest in favorite activities, etc.) were not caused by a medical condition. The doctor explained to Fernando that he might be suffering with *depression* and offered to refer him to a mental health provider for further assessment and treatment. Fernando immediately thought: “This is worst than I thought!” “I am crazy!” “He will put me away?” “They will drug me.” The family doctor explained to Fernando about depression, how treatable it was, how psychotherapy would be helpful, and that he might not need to take antidepressants, but he had to see the mental health provider (“*profesional en salud mental*”). Fernando stated “I do not think the mental health provider can help me;” “I just need to be stronger and this will go away.” His family doctor asked Fernando to think about it and referred him to the mental health provider.

Fernando missed his appointment with the mental health provider. He was afraid that he would be sent to the “nuts’ house.” He told his wife and his *compadre* Lorenzo that he wanted to solve his problems on his own. He remembered the saying, “*Los trapos sucios se lavan en casa*” (The dirty cloth is washed at home), and rejected the idea

of having to tell his problems to a stranger. His wife insisted that Fernando give it a try and encouraged him to get help. Fernando consulted with his Lorenzo and the “*padrecito*” (priest) at their church. Both, *compadre* Lorenzo and the *padrecito* exhorted Fernando to seek mental health care. They both told him about some people they knew who successfully received professional help for their emotional difficulties. The *padrecito* reminded Fernando “*Dios ayuda a esos que se ayudan a sí mismo*” (“God helps those who help themselves”). Fernando decided to get a new appointment and start treatment for his depression.