

Adaptation of the Preventive Intervention Program for Depression for Use with Predominantly Low-Income Latino Families

EUGENE J. D'ANGELO*
 ROXANA LLERENA-QUINN†
 RACHEL SHAPIRO‡
 FRANCES COLON‡
 PAOLA RODRIGUEZ‡
 KATIE GALLAGHER‡
 WILLIAM R. BEARDSLEE‡

This paper describes the process for and safety/feasibility of adapting the Beardslee Preventive Intervention Program for Depression for use with predominantly low income, Latino families. Utilizing a Stage I model for protocol development, the adaptation involved literature review, focus groups, pilot testing of the adapted manual, and open trial of the adapted intervention with 9 families experiencing maternal depression. Adaptations included conducting the intervention in either Spanish or English, expanding the intervention to include the contextual experience of Latino families in the United States with special attention to cultural metaphors, and using a strength-based, family-centered approach. The families completed preintervention measures for maternal depression, child behavioral difficulties, global functioning, life stresses, and an interview that included questions about acculturative stressors, resiliency, and family awareness of parental depression. The postintervention interview focused on satisfaction, distress, benefits of the adapted intervention, and therapeutic alliance. The results revealed that the adaptation was nonstressful, perceived as helpful by family members, had effects that seem to be similar to the original intervention, and the preventionists could maintain fidelity to the revised manual. The therapeutic alliance with the preventionists was experienced as quite positive by the mothers. A case example illustrates how the intervention was adapted.

Keywords: Adaptation; Depression; Preventive Intervention; Latino Families

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*Chief, Division of Psychology, Department of Psychiatry, Children's Hospital, Boston, MA

†Children's Hospital, Boston, and Harvard Medical School

‡Children's Hospital, Boston

Correspondence concerning this article should be addressed to Eugene J. D'Angelo, Division of Psychology, Department of Psychiatry, Children's Hospital, 300 Longwood Avenue, Boston, MA 02110. E-mail: Eugene.dangelo@childrens.harvard.edu

The World Health Organization estimates that depression will be the second leading cause of morbidity by the year 2020 (Murray & Lopez, 1997). Children of depressed mothers have an increased risk of major childhood depression disorder, anxiety disorders, and a variety of other problems (Weissman et al., 2005). A range of negative experiences, such as decreased opportunities for employment, higher rates of poverty, prejudice, and discrimination, and a greater likelihood of physical ailments are associated with risk for depression among racial and ethnic minorities including Latinos (Plant & Sachs-Ericsson, 2004).

Despite the need, racial/ethnic minority and low-income families underutilize mental health services (Lopez, 2002; Organista, Muñoz, & Gonzalez, 1994). These issues highlight the need for more accessible and culturally sensitive mental health services to these communities (US Department of Health and Human Services, 1999). Depression prevention programs offer one way to provide services to families who otherwise might not utilize services (Cardemil, Kim, Pinedo, & Miller, 2005; Podorefsky, McDonald-Dowdell, & Beardslee, 2001).

To address these concerns, we chose to adapt an evidence-based prevention, the Beardslee Preventive Intervention Program for Depression (PIP), for use with Latino families for the following reasons. First, given the importance of the family in Latino culture in general (Falicov, 1998) and for the immigration experience in particular (Llerena-Quinn & Pravder Mirkin, 2005), a family centered, strength-based approach (e.g., PIP) is considered to be useful and effective in a variety of prevention programs (Beardslee & Knitzer, 2003). Second, a strong evidence base exists to support the PIP's use for prevention of depression in families (Beardslee, Gladstone, Wright, & Cooper, 2003; Beardslee, Wright, Gladstone, & Forbes, 2008). It has received high ratings from the review by the National Registry of Effective Programs (SAMHSA's National Registry of Evidence-based Programs and Practices, October 2006). Third, PIP was selected because of its documented transportability to other settings especially with single parent families from racially diverse backgrounds who share many characteristics with the Latino population (Podorefsky et al., 2001).

THE PIP — THE FAMILY TALK INTERVENTION

As outlined in Table 1, the core PIP is a six session manualized series of meetings designed to enhance strength and resilience in youngsters whose parents are depressed. In this paper, the concept of resilience is based on earlier risk studies using the PIP and includes three important dimensions, namely, the capacity to accomplish age-appropriate developmental tasks, the capacity to engage in relationships, and the capacity to understand and reflect on the experience of parental depression (Beardslee, 1989). Thus the conceptualization of resilience was different and not simply the opposite of the presence of depressive symptomatology. It was built on both empirical study of children of depressed parents and a broader conceptualization of the role of self-reflection and self-understanding (Beardslee & Podorefsky, 1988). Additionally, resilience is also based on the premise that parents who are depressed can be effective parents when they understand what is occurring in their families, when they know about their depression and receive treatment if needed, and increase the focus on their parenting competencies. Parental depression diminishes the parental capacity to communicate clearly with family members, to effectively problem-solve, and/or to successfully take actions to support their youngsters' development (Beardslee, 2003).

TABLE 1

*Outline of Original Preventive Intervention Program for Depression****Session 1: Establishing the Therapeutic Relationship & Constructing the Family History of Depression***

- Alliance & collaboration
- Orientation to the intervention
- Collect history of parental depression

Session 2: Experience of Depression and Psychoeducation

- Review the previous session
- Elicit history of family's experience with affective illness, with particular attention to the spouse's/partner's perspective
- Psychoeducation about the etiology, symptoms, and treatment of the pertinent affective disorder
- Help parents review their child's current functioning and to express particular concerns about his/her adjustment
- Help parents prepare their children for the meeting with the clinician and help them voice their worries about the interview

Session 3: The Meeting with the Child(ren)

- To acknowledge the importance of the child's perspective & to develop a rapport with him/her
- Assess child's current functioning & understanding/response to parental depression
- Help the child articulate questions or concerns for family meeting
- When appropriate, impart information about depression geared to child's concerns and developmental level

Session 4: Planning the Family Meeting

- Provide parents with a general review of their child's functioning
- Link parents' perception of depression with that of the child's experience of their affective illness
- Facilitate participation in the joint task of planning a family meeting

Session 5: The Family Meeting: Facilitating the Creation of a Shared Understanding of the Parental Illness

- To review with the family the purpose of the family meeting(s) & information from last session about depression & resiliency
- Facilitate the creation of a shared understanding of parental illness, incorporating the affective experience of all family members
- Empower parents to conceptualize & present the depression to their children as an [illness] that may have affected the family in various ways & can now be discussed

Session 6: The Review Meeting: Planning for the Future

- Review with the parents the purpose of the family meeting & whether the purpose was met
- Review information shared with/by children and discuss their immediate and present reactions to openly discussing their affective disorder
- Review the purpose/limitations of the intervention and assist them in making long-term plans to address the impact of parental depression on family functioning

Therefore, the aim of this preventive intervention is to help families break their silence and be able to have effective conversations about depression and related matters with a focus on how they will both overcome the effects of parental depression and build resilience in the youngsters.

The PIP includes a strong narrative component involving the coconstructing among family members of a narrative regarding the circumstances that led up to and the positive events that were often obscured by the parental depression (Beardslee, 2003; Focht-Birkerts & Beardslee, 2000). It is important to note that, in this intervention, the definition of "family" is based on the family's own identification of its members.

PERSPECTIVES ON THE ADAPTATION PROCESS

Because the evidence continues to grow regarding the effectiveness of preventive mental health intervention programs, it has become increasingly important that they are constructed with flexibility and appropriately adapted to meet the cultural complexities of a diverse society (Bernal & Scharrón-del-Río, 2001; Levant, 2005). Despite this need, few preventive interventions aimed to reduce the risks for developing serious mental health problems have been adapted to address the specific needs of ethnically diverse communities.

Rogler (1989) has noted that adapting an intervention to a new setting leads to transformation of the intervention, hence, has recommended that cultural adaptation needs to occur at the earliest stage of research. Similarly, the Institute of Medicine's report (1994) recommends that the development of preventive interventions utilize rigorous experimental designs which include pilot studies to develop manual-based interventions, to determine their safety and feasibility before use in broader randomized clinical trials. Because randomized control studies require a large-scale and expensive effort, Onken, Blaine, and Battjes (1997) proposed a Stage Model of research, demarcating three divisions in a rigorous scientific process that begins with initial clinical innovation, transitions to efficacy studies, and concludes with effectiveness research. Of particular relevance to this project, Stage I consists of pilot/feasibility testing, manual writing, training program development, and adherence/competence measure development for new and untested treatments (Rounsaville, Carroll, & Onken, 2001). The aims are to evaluate the extent to which patients will accept the newly adapted intervention (e.g., they complete the requisite course of treatment and do not drop out), whether participants can be successfully recruited to participate in this type of prevention project, and whether it is feasible to deliver the intervention with the appropriately identified clinicians. Matos, Torres, Santiago, Jurado, and Rodriguez (2006) have utilized this Stage I schema to adapt parent-child interaction therapy for use with Puerto Rican families. We chose to use this Stage I schema in our adaptation, focusing on the study of a few families in depth, utilizing the input from formal pre-/postintervention assessments and family feedback to provide information about the effectiveness of the adapted intervention.

Thus, the purpose of this study was to evaluate the safety and feasibility of an adaptation of the Beardslee PIP for use with predominantly low-income, Latino families (L-PIP) before utilizing it in a more formal clinical trial. We provide a description of the formal evaluation of 9 cases with pre- and postassessment by clinical interviewers independent from the intervention content and self-reports to determine whether the adaptation was (1) safe for use with Latino families in a large scale clinical trial; (2) feasible, that is, whether its effects were considered beneficial and satisfactory to the Latino families who participated in the adaptation project and approximated those from the use of the original protocol in earlier studies; and (3) adapted with fidelity and able to be taught to multiple preventionists who faithfully utilized it.

I. The Adaptational Process

For 3 years, a multidisciplinary, multiethnic group of researchers, including bilingual/bicultural preventionists, met weekly to develop the adaptation to the original program. Two investigations that focused on adaptation guided this process. First, as part of the adaptation of the PIP for use with urban, low-income families, Podorefsky

et al. (2001) demonstrated that an intervention can be modified while retaining fidelity to the core principles guiding the delivery of the intervention. The second major influence in this adaptive process was provided by Griner and Smith (2006). They have highlighted four basic methods that facilitated effective *cultural* adaptations. First, there should be incorporation of cultural values and the context from which they emerged into the interventions. Second, to increase client perceptions of clinician understanding, they should be served by professionals of the same race/ethnicity, individuals who were culturally aware and who were fluent in their primary language. Third, the interventions should be easily accessible, flexibly scheduled, and sensitive to the life demands of the clients. Fourth, clinicians should work collaboratively with supportive resources compatible with the client's community, spiritual traditions, and extended family.

Staff members from the Latino Treatment Team at Children's Hospital Boston and other members of the department began with a review of information that the team had gathered from Latino families through focus groups and their clinical experience. Eight low-income, Latino mothers met with two bilingual/bicultural clinicians. The discussion focused on depression and resilience, the ways clinicians conveyed respect for families in an alliance-building effort, the importance of being able to describe one's immigration/migration narrative and its impact on an individual's emotional functioning, the desire for information about a range of life challenges and not merely depression, and their challenges in both communicating with children whose Spanish was not highly developed and the concerns about the values of the dominant culture. Second, the literature on risk and resiliency in Latino families was reviewed with a focus on identifying prominent protective factors within the Latino culture. Third, an examination was undertaken of the literature about research frameworks that are ecologically valid for Latino populations (Bernal, 2006; Bernal & Scharrón-del-Río, 2001; Cardemil et al., 2005; Griner & Smith, 2006). Fourth, after pilot testing the original PIP with two Latino families, more culturally relevant content and an expanded method of delivery were incorporated into the adaptation. As such, the key features of the PIP adaptation were the following:

1. The importance of bilingual and bicultural providers as a resource to enhance resilience and to promote the strength-based, family intervention.

Differences in language and culture have been identified as a source of acculturative stress for individuals who relocate to a new, dominant culture (Hovey & King, 1996).

2. The six PIP sessions were converted into modules

Based on the pilot testing of the original PIP with two Latino families, the six session intervention was changed to a six "module" program so that, if needed, the topics covered in each module could be flexibly provided without the temporal limitation of a session format. Subsequently, a move away from sessions to modules afforded families the opportunity to share at their own pace their experiences about the challenges they face adjusting to the dominant culture. For example, it was anticipated that the sessions would incorporate more than a focus on parental depression, and extend to descriptions of the problems with access to healthcare, the immigration/migration experience, and the perceived intergenerational difficulties regarding changing cultural values. The module could be resumed in a subsequent session until reaching its completion. In part, this could be helpful because, based on feedback from bilingual/bicultural clinicians who reviewed the original PIP, there is

often a need to translate the statements made by one family member into either Spanish or English for others and to provide for explanations of the cultural issues or concerns being expressed by family members—extra steps that are not characteristic of families who have utilized the original PIP, where common language and culture were generally shared by participants.

3. Expanded content of the history-taking narrative

The content of the initial history-taking in Module I, and continued in Module II, was expanded to include immigration/migration histories, and sharing narratives about the complexities of adapting to a favorable/unfavorable host culture, to be respectfully responsive to the families' current concerns, which might extend beyond the risk for depression, and to determine the language and cultural value differences among the family membership.

4. Expanded emphasis on alliance-building and collaboration

Because of the documented mistrust of health care providers by minority patients, conveying respect in ways that were meaningful to Latino families and the development of "trust" (*confianza*) would be a crucial element for this adapted intervention (Falicov, 1998). This was accomplished by (1) *Transparency of intention*, which was conveyed by a careful description of the intervention and its goals, including acknowledgement of and respect for the parents' wish to help their children as well as to identify and reinforce the family's strengths and resources. (2) *Respect (respeto) for the parent's and family's perspective* was evidenced by the way the preventionist addressed the family, with a focus on forming a warm, collaborative rather than a hierarchical relationship. (3) *Ensuring that the family felt their concerns were being heard and responded to* by beginning every session with a "Check-In" and by asking about their current concerns.

5. The expanded and ongoing role of psychoeducation

Psychoeducation was thought to be important to provide at all points throughout the intervention, particularly as questions arose from various family members. It began with exploration of what the parent and, subsequently, other family members already understood about depression and their related concerns. The goal was to expand understanding of depression and resilience using existing family metaphors as they might incorporate culturally and linguistically appropriate explanations and written materials that were relevant to the contextual realities of the family's cultural, social, and minority status.

6. Modifications to meeting with the children

The same attitudes toward establishing an alliance, communicating respect, and developing trust were important for the meeting with the children. It was important for the children to know that their mothers supported their participation, that the *respeto* in the parent-child relationship was explicit, and that permission was given for the children to ask questions and, hence, did not constitute a violation of *respeto* or loyalty to the family.

7. Parental preparation for the family meeting

Planning the family meeting in Module IV offered the first opportunity to assist the mothers in integrating the information obtained from their children with their experiences in other modules. Information was provided to mothers about the similarities and differences about raising children in the United States versus their country of origin. Parents were also prepared for potentially difficult conversations about events their children had witnessed that were associated with parental depression,

family stressors, and sociocultural difficulties. Decisions could be made with the parents about subsystems within the family working separately on particular issues (e.g., adolescents meeting separately from their younger siblings with their mothers to discuss expectations, responsibilities, and privileges) and/or to find the proper “language” to express themselves during the larger meeting.

8. Modifications to the family meeting

The main purpose of the meeting was to facilitate the creation of a shared understanding of the family experience of the parental depression by focusing on strengths and incorporating the experience of all family members. Because of the social, economic, and cultural experiences of Latino families, the organization and content of the family meeting is expanded beyond understanding of parental depression to include the multiple contexts in which the depression and their lives were embedded. Barriers in communication were addressed by (1) providing some guidelines for the conversation that included an agreement to allow family members to talk openly, (2) negotiating how language differences were to be managed in the conversation, and (3) attempting to both identify and bridge acculturation and generational barriers within the family.

9. Follow-up meeting

The final module with the mothers provided an opportunity to review the entire intervention, answer further questions, and examine what was learned, what was beneficial for the family, and what proved to be less useful. The preventionist could also help the family develop a plan for what still needed to be done beyond the intervention—for problem-solving and to help facilitate referrals for services to address the various problems that continued to stress them (Griner & Smith, 2006). The preventionist could discuss with the parents future developmental challenges and help them know what resources are available to them. It provided an additional opportunity to underscore that cultural transitions experienced by Latino families may be part of their ongoing immigration/migration experience and were not reflective of bad parenting. In this way, the efforts of the adapted intervention were a first step in a journey toward “a better life” (*una mejor vida*).

10. Management of family crises during the intervention

Consistent with the recommendations of Griner and Smith (2006) and the earlier findings of Podorefsky et al. (2001), an important modification throughout the six modules was to flexibly deal with unexpected family crises and stressful events should they arise. The work on the tasks of any particular module might be postponed to address the more pressing concerns emanating from the family crisis. Once a plan was in place or the problem resolved, the preventionist could return to the incomplete module.

II. Stage I Investigation

METHOD

Recruitment

Upon receiving approval from the Institutional Review Board, families who define themselves as Latino were recruited through the Department of Psychiatry at Children’s Hospital in Boston. Enrollment criteria included a parent with a current or history of serious depressive disorder occurring at least in the past 3 months (the convergence of both the treating clinician’s DSM-IV diagnosis and a record review by a

senior project investigator using the DSM-IV criteria for depressive disorders to confirm the diagnosis); absence of current drug or alcohol addiction in the parents; the absence of significant life crises (e.g., new medical diagnosis of serious illness, death of a family member) that the parent's therapist, if relevant, felt would be too stressful for the family to participate in this project, and the presence of a professional who was treating the adult affective disorder or could be involved should such treatment be necessary. Families were reimbursed for participating in the study and childcare was provided if needed. As with the original intervention, scheduling of the sessions was flexible and could be provided either in the clinic setting or in the family's home, although families requested that all sessions be provided in the clinic. All children participated in the intervention, however, because this project was focused on manual development in anticipation of a randomized clinical trial and due to resource constraints, one child in each family participated in the assessment process. This child was selected based on being aged 7–17, and not exhibiting a depressive disorder, psychosis, or significant developmental disorder. In most cases, the eldest child in the family who met criteria was recruited and assented to complete the pre- and postintervention measures.

Measures

The measures selected for this study represented the dimensions investigated in previous studies (Beardslee et al., 1998) and those that evaluate issues of acculturative stress and multiple life stressors that are considered to potentially increase risk for depression within the Latino community (Suarez-Morales, Dillon, & Szapocznik, 2007). In addition to making available the Spanish versions of the Child Behavior Checklist (CBCL) and Hamilton Depression Rating Scale (HDRS), all self-report and semistructured interview measures were translated into Spanish. These translated measures were reviewed by three bilingual/bicultural clinicians for the appropriateness and cultural sensitivity of the content and were modified, where appropriate, during pilot sessions. Parents and children were offered the option of completing the measures either in Spanish or in English. While all of the children completed the English versions of the relevant measures, 8 out of 9 parents opted to complete the Spanish versions. The measures utilized were as follows:

Parent Depression

The HDRS (Hamilton, 1960) was used to identify the presence and severity of depression at preintervention among the participating mothers. Ramos-Brieva and Cordero-Villafafila (1988) investigated the reliability and validity of the Spanish version of the HDRS and found it to have good psychometric properties. A total score above 17 is indicative of severe depression.

Global Assessment Scale (GAS; Endicott, Spitzer, Fleiss, & Cohen, 1976; Child-GAS; Shaffer et al., 1983)

The clinical assessors used the GAS to rate each mother's and child's level of functioning at both the pre- and postintervention interviews.

Semistructured Interviews about the Intervention

Pre- and postintervention assessments are used to elicit qualitative and quantitative information about the parent's perception of the impact of depression on the

family and the experience of families after they have completed the intervention (Beardslee et al., 1992). The interviews were completed with both mother and participating child.¹ The original, preintervention interview assesses prior factual knowledge and concerns about affective disorder, the experience of depression in the family, the nature of communication among the members, and the effects of parental illness on the children. The preassessment was adapted to inquire about the immigration/migration history, the acculturative experience, and the resources/strengths both within the family and their social network that have promoted resilience. Responses from the preintervention interviews were used to identify the number of acculturative stressors that were present in the lives of these families. Consistent with Suarez-Morales et al. (2007), these stressors include: (1) language stressors (parents/children use different languages at home), (2) experience of discrimination, (3) perceived cultural conflicts between original and host cultures, and (4) intergenerational conflicts.

The postintervention interviews contained additional questions and self-rated scales about the participant's experiences with the intervention, whether it was distressing, and the extent to which it was helpful. Two rating scales developed by Beardslee et al. (1997) for use with both parents and their children who have participated in the PIP were used to supplement this interview:

- *Impact of the Project Rating Scale* Parents were asked to rate their overall satisfaction with the intervention (1 = *not at all happy* to 7 = *very happy*) and four items about degree of helpfulness of the intervention (1 = *stayed the same* to 7 = *a great deal*) in the following areas: Communication between parent and child, better mutual understanding, and perceived changes in their relationship.
- *Modified Concerns Scale*. The parents were asked to identify up to three concerns that they felt were present in their families' lives and rated them on a 7-point Likert scale for the degree to which the intervention program impacted these concerns.

Life Stress

The Recent Life Changes Questionnaire (RLCQ; Miller & Rahe, 1997) is a measure designed to assess various life changes and provide a rating of severity of life stress. Total scores at or above 300 are considered to indicate high stress during the past 6 months.

Therapeutic Alliance

The Integrative Psychotherapy Alliance Scales (Pinsof & Catherall, 1986), a self-report measure, was completed by each mother assessing her relationship with the therapist.

Child Behaviors

The Spanish Version of the CBCL (Achenbach & Edelbrock, 1983) was used to identify the degree of behavioral difficulties among the children at preassessment.

¹ Copies of the semistructured interviews and the manual for the adaptive preventive intervention can be obtained from: William Beardslee, MD, Department of Psychiatry, Children's Hospital, 1 Autumn St., Boston, MA 02115.

Therapist Fidelity Rating Form

This is a rating form developed for the study which permitted a clinician who is independent of but knowledgeable about the adapted intervention to rate randomly selected tape-recorded sessions for therapist's fidelity to the intervention protocol. As such, it was possible to determine to what extent the intervention was delivered both completely and consistently with the directives of the adapted manual.

Three preventionists, one psychologist, and two social workers underwent an extensive training program to ensure that the intervention was delivered in a standard fashion. The training included a detailed review of transcribed cases, review of both the original and adapted manuals, extensive viewing of training tapes, and meetings to discuss the conduct of the intervention with those skilled in its use. Ongoing weekly peer supervision occurred throughout the course of the project.

RESULTS

Sample

Nine out of 11 families who were screened met the project's inclusion criteria. The 2 families excluded from the project had mothers who were exhibiting overt symptoms of bipolar disorder and were referred back to their clinicians for continued treatment.

Basic demographic information can be found in Table 2. While preassessment data is available for all participants, a 7-year-old boy from one family did not participate in the postassessment interview nor complete the rating scales. Because of his age, he lacked understanding of the questions and was unable to read the assessment items adequately.

TABLE 2
Demographic Information about the Participants (N = 9 Families)

Variable	Description of the participants
Maternal age	$M = 39.9$ years ($SD = 5.51$; Range: 30–45)
Marital status	1 single; 1 married; 6 separated; 1 divorced (5 mothers had a partner)
Income level	7 families with yearly incomes $< \$20,000$; 1 family between $\$40,000$ to $\$50,000$; 1 family greater than $\$60,000$
Maternal education	2 with < 7 years of school; 2 high school graduates; 4 some college; 1 college graduate
Work status	1 mother working outside the home; 4 partners working; 4 nonrespondents
Place of birth	5 Puerto Rico; 3 Dominican Republic; 1 Colombia
Age at immigration/ migration	$M = 25.3$ ($SD = 6.39$)
Years in US	$M = 14.3$ years ($SD = 8.92$)
Current language	7 exclusively Spanish; 2 bilingual
Number of children in family	Median = 2; Range: 1–5
Age of participating child	$M = 11.0$ years ($SD = 1.94$; Range: 7–14)
Gender of participating child	5 female, 4 males
Child's language at home	7 bilingual; 2 only English
Child's language with peers	4 Spanish

All of the mothers were either US citizens or had obtained documented status upon arrival in the country. The adapted preassessment interviews revealed that the majority of the mothers maintained close contacts with relatives and friends from their countries of origin who lived nearby, called relatives in their homelands daily or at least weekly, belonged to cultural community organizations or churches with close ties to their homelands, and lived in predominantly urban, Latino neighborhoods.

With respect to acculturative stress, 4 of the mothers reported that they had experienced overt discrimination since arriving in the United States. When asked whether they believed they had acquired values, customs, or lifestyles that were similar to the host culture, 4 mothers said "no," two said "yes" but felt it was limited to food and meal times, and three said "yes," noting their embrace of holidays and styles of interpersonal interaction. Only three mothers reported having any friends who were non-Latinos.

Intervention Delivery

The duration of the intervention was varied across families, ranging from 3 to 7 months to completion, with an average of 7.33 sessions ($SD = 1.0$). The variability in the number of sessions was due to the preventionists' efforts to be flexible for the families. No families dropped out or showed any wish to discontinue at any point in the project.

Clinical Status of Mothers

At preintervention, the mothers had a mean HDRS score of 23.63 ($SD = 7.80$, range = 10–34). Maternal GAS preintervention scores revealed variable impairment in functioning ($M = 58.38$, $SD = 12.37$). Postassessment maternal GAS ratings revealed statistically significant improvement ($M = 61.75$, $SD = 12.67$; $p = .017$). The GAS preintervention scores for the children in the project reflected minimal to transient impairment ($M = 78.17$, $SD = 10.69$), which complemented the relatively low symptom ratings on the CBCL ($M = 59.86$, $SD = 10.76$), with no significant differences on either child measure at postassessment. Six out of the 9 mothers had scores indicative of high levels of life stress during the past 6 months before participating in the intervention, as measured by the RLCQ ($M = 390.22$, $SD = 230.72$, range = 46–770).

Children's Knowledge of Parental Depression

During the preassessment interview, all of the mothers reported the belief that their children did not know about their depression. However, when the children were interviewed, only 3 did not know their mother was symptomatic for depression, 3 others had observed somatic or depressive-like symptoms (e.g., difficulty getting out of bed, crying, or headaches), and 2 clearly reported that their mother was depressed.

Safety and Response to the Intervention

All of the mothers reported that participation in the intervention was neither hurtful nor unhelpful. Moreover, all of the mothers reported that they felt that their families had benefited from participation in the project. As one mother observed, "I think my family learned a lot in this study and found it as an additional support to us." Another

reported learning that communication is important and that “everyone has a voice in her family.” She also reported improved coping skills.

Of the 8 children interviewed, 7 reported that they did not feel that participation in the project was either stressful or unhelpful. One adolescent stated that she felt some distress because she underappreciated that her mother had been sad. Further review of her responses to the semistructured interview and to her self-report ratings reflected a high level of satisfaction with participation in the project suggesting that this “distress” was more a sense of embarrassment about not recognizing her mother’s depression, rather than a more enduring problem resulting from this heightened awareness. Six of the children reported that they were “glad to be involved in the project,” with 2 children reporting that they felt “neutral.” However, their overall happiness with participating in the intervention was rated quite positively on the postintervention rating scales, suggesting that there were no adverse effects from involvement in the project.

Satisfaction

Five postintervention, 7-point Likert-type ratings provided the parent and child the opportunity to evaluate the intervention for both degree of helpfulness and satisfaction. Means and standard deviations are detailed in Table 3.

Parent and child responses were similar for all but the question on improvement in communication between parent and child. For this item, parents reported a significantly greater increase (Wilcoxon matched-pairs signed ranks test, $Z = -2.37$, $p = .018$) in ease of talking with their child than the children reported in return.

Maternal ratings of therapeutic alliance provided an additional indication of overall satisfaction with the intervention. The mean alliance score for the 9 participants was 6.97 ($SD = 0.045$, possible range = 1–7). These therapeutic alliance scores are quite high, nearly at the ceiling of possible scores, and significantly higher ($t = -5.83$, $df = 21$, $p < .0001$) than the therapeutic alliance scores ($M = 5.4$, $SD = 0.8$) found in a pilot study of the original intervention (Beardslee et al., 1992).

Parental Concerns

During the preintervention interview, all of the mothers reported concerns about their children’s continued development and the impact of the potential differences

TABLE 3
Parent and Child Improvement Ratings based on Postintervention Self-report

Question	Parent ($n = 9$)		Child ($n = 8$)		Wilcoxon matched-pairs signed ranks test Z
	<i>M</i>	<i>SD</i>	<i>M</i>	<i>SD</i>	
Able to talk to child/parent more easily	6.1	2.0	3.9	1.9	-2.37*
Able to talk with others more easily	6.1	1.3	4.1	2.9	-1.70
Relationship with child/parent better	5.9	2.0	4.8	2.1	-1.90
Project helped me understand child/parent better	6.3	0.9	5.6	1.7	-1.19

Note. * $p < .05$.

between their cultures of origin and that of the culture in the United States. Of particular concern was the risk of violence in their communities and the impact that might have on their children. Finances, housing, work, and transportation were also frequently mentioned.

After the intervention was completed, 9 families rated the degree of helpfulness of the intervention in addressing their concerns during the intervention. Parents reported positive help from the intervention, with a mean rating of 5.31 ($SD = 1.54$, range = 1–7). As predicted, higher postintervention ratings of usefulness of the intervention to address worries were found in parental concerns related to child physical health, academic performance, and environmental worries ($M = 5.22$, $SD = 1.48$), child mental health/behavioral concerns ($M = 5.71$, $SD = 0.76$), parent mental health/behaviors/child relationships ($M = 6.67$, $SD = 0.58$), and parent/spouse/grandparent physical health ($M = 5.00$, $SD = 1.73$) because they were the focus of the intervention. The only parental concerns that were scored as below moderately helpful involved housing, bills, and physical health and safety, which were not targeted by the intervention.

Therapist Fidelity

A bilingual evaluator randomly selected two taped sessions for each of the three preventionists and found that 92.6% of the content elements for the adapted, manualized modules were delivered in the taped modules, the overall tone was positive, and 100% of the families were cooperative and enthusiastic.

CASE EXAMPLE

The following case example illustrates the aforesaid key principles of the adaptation. In this case, the adaptations included the expanded content of the history-taking for the mother, emphasizing the importance of alliance-building and collaboration between preventionist and family members so that their important concerns could be addressed, providing the child with permission to ask questions about parents and incomplete features of the family's history, extended psychoeducational information beyond depression to other worries, identification of barriers that had occurred in the family related to discrepancies between maternal cultural values and the children's aspirations during the acculturative process, the preventionist translating between mother and children, and creation of plans to further address the culturally based difficulties identified during the intervention program. Names and other identifying details have been changed to preserve confidentiality.

Module I

Ms. Soto is a 41-year-old mother of two children, a bright and healthy 10-year-old girl, Milagros, and a 7-year-old boy, Isaac, who is diagnosed with attention deficit hyperactivity disorder (ADHD). She was born in Puerto Rico where her family still resides. She was on disability due to chronic medical conditions although she had two successful surgeries in Boston.

In the initial interview, Ms. Soto shared her story with a great deal of feeling. She began with her arrival in Boston to obtain medical treatment, which is when her depression began. In Puerto Rico, she had been told that she would die at age 18 since her medical condition was considered inoperable. She met the children's father

shortly after her arrival in Boston; he treated her with kindness. She encountered difficulties learning English and finding acceptable housing and employment. This man seemed her way out of a difficult situation. When she discovered that her partner was not what he seemed and was physically abusive, she attempted to terminate the relationship, but felt socially isolated because they had moved away from Boston. After Milagros was born, she left this relationship; however she returned, and had Isaac. Subsequently, she was able to terminate her relationship with the father, yet, worried that her children had difficulties because of the choices she had made.

Module II

The psychoeducational component was critical because she was filled with guilt over her choice of a partner, and feared that her son had insurmountable difficulties. She believed that perhaps God was punishing her for this sin (“I have remorse”—*Tengo remordimiento*), but tried to believe that “things happen because it is God’s will” (*las cosas pasan porque Dios quiere*). Talking about ADHD, considering the possibility that her partner had an undiagnosed psychiatric condition, and that she had a history of learning difficulties and attentional problems helped her feel less responsible. In particular, having more information about ADHD and connecting it to her son’s behavior was quite helpful, since she had thought that Isaac could control his behaviors.

One of Ms. Soto’s main concerns was related to the children’s constant fighting. She wanted her daughter to understand her brother’s condition and to have more patience with him, since their arguments worsened her migraines.

Ms. Soto also wanted them to understand the difficulties in being a single parent and the related economic stressors. She wanted her children to know that despite the fact that her extended family lived in Puerto Rico, she remained in New England because of the excellent opportunities available to them for health care and education.

Module III

Milagros discussed her worries about her mother’s health. While she was unaware of the maternal depression, she knew that her mother complained of headaches and sometimes stayed in bed. She also wanted an explanation of her mother’s “medical problems” since she had heard that “Mom almost died at age 18.” She also worried that her brother could get hurt due to his impulsivity. Using psychoeducation, the preventionist talked with her about Isaac’s ADHD. Milagros was surprised, and mentioned that she could be more understanding. She also expressed a desire to spend time alone with her mother, and noted her difficulties communicating with her mother in Spanish. (She was fluent in English; however, her mother spoke little or no English.) Additionally, she mentioned her desire to make more friends and was curious about her biological father. Milagros described depression as similar to “having a bad day.” She described her mother as sometimes getting “sad, stressed or mad” and was able to relate her mother’s symptoms to general symptoms of depression, especially her irritability. She understood that her mother did not like the constant fighting between the children. Although the session with Isaac was brief due to attention and language difficulties, he readily participated.

Module IV

Following the child sessions, Ms. Soto was delighted that the preventionist had observed so many strengths in both children. The preventionist obtained information from Isaac's teacher who described him as in the top reading group and a wonderfully gifted artist. She had added that Isaac was a child requiring an orderly, rigorous, and intellectually challenging environment, doing poorly with little or no structure. The information was helpful in understanding him whom others, including Ms. Soto, considered so demanding. Ms. Soto thought that "good discipline" helped build resilience, and that being bright and doing well in school could protect her children in the future. Her biggest concern was anticipating adolescence "when the monster comes out" (*cuando el monstruo sale*). In response to her request, specific parenting techniques to reduce sibling fighting as well as information about raising adolescents were reviewed at each session as questions and difficulties arose.

Module V—Part 1

Based on the mother's request, the first family meeting occurred with her daughter alone, because Ms. Soto was prepared to answer some of her daughter's questions. Milagros asked her mother how she had arrived in the United States. "Did you come by plane or boat?" Ms. Soto shared her story of coming here for health reasons. Since Milagros was worried about her mother's health, she asked whether her mother might die. The preventionist, with Ms. Soto's full support, had contacted the surgeon who had said that she had done well with the surgery and believed she would do well in the future. Ms. Soto paraphrased his response and addressed Milagros's concern to her daughter's satisfaction. After much practice in Module IV, Ms. Soto was prepared to address questions about Milagros's father, a most difficult topic for her to discuss. She had decided not to talk about the details of the father's negative attributes but rather simply stated that he had not been good to her and she had left him. Her explanation for why there was no contact between them made sense to her daughter. It was clear from the beginning that Ms. Soto also wanted to talk to her daughter about her depression and the impact on the children, even though the word *depression* had not been known to the children. The term "bad day" was chosen by Milagros and then used by Ms. Soto, which meant, in this family, Ms. Soto's not wanting to go out or do things, "like when you want me to go to the pool and I just don't feel like going." Milagros had thought that her mother was tired or sick. It was reassuring that her mother had something that could be labeled, hence, did not sound as frightening or life threatening as had her medical condition. The preventionist needed to simultaneously facilitate both the language communication between them and their making meaning of depression. They also had an important discussion about religion, which was a source of difficulty between them. Ms. Soto wanted Milagros to know that her current faith helped her to feel better and reduced her symptoms of depression. In this session, linking Ms. Soto's past history to the present for Milagros was important in establishing a shared understanding of her experience.

Module V—Part 2

The second family meeting included both children and was more challenging because Isaac spoke no Spanish, hence, the preventionist needed to translate

and facilitate mutual understanding. Ms. Soto acknowledged her children's strengths, that they were intelligent, had special artistic talent, and, as a result, manifested resilience. She recognized her own talents in crafts and visual arts, and that their father was an intelligent man. Ms. Soto had not known that her son could express himself so well in English, and this became clear because Isaac was very talkative and wanted his mother to listen to him. When Milagros talked about how annoying Isaac was, the preventionist asked her to describe what she had learned about ADHD. She said, "When you have ADHD, you get really hyper and you do things without really meaning it." Isaac said he was sorry and that "It's hard to think about what I need to do first." Neither Ms. Soto nor Milagros had any idea that he was aware of this issue.

Later in the session when he yelled out, "I hate my name," it was Milagros who translated his explanation when he reported that he was always teased about his name. Ms. Soto used this opportunity to tell them both how lucky she felt to have them and also how she came to choose their unusual names. The daughter's name meant "miracle" in Spanish, chosen because Ms. Soto had been told she could not have children. She named her son after a strong and important figure from the Bible. Both Ms. Soto and Milagros became very empathic toward Isaac and were surprised that he was such a keen observer as was evidenced by various comments in the session. At other points in the sessions, the preventionist reframed their misbehavior as their way of expressing worry about their mother, which they both acknowledged. Milagros proceeded to hug her brother several times during this session, causing Ms. Soto to smile and say how much she liked seeing this interaction. The preventionist was able to remark throughout the session about how much affection they had for one another. At the end of the session, the children agreed to reduce their fighting. Ms. Soto said she would try to intervene earlier and before arguments escalated. She also agreed to speak to the school about the bullying described by Isaac and said she would arrange to meet Milagros's friend to plan a play date. The session ended with everyone saying something positive about the others.

Module VI

In the final session with Ms. Soto, she reported many positive changes since the family meeting. She said she was talking more to Milagros. She stated that knowing her daughter was worried about her health encouraged her to check in with her more regularly. She saw her daughter in a different light and as a person of greater maturity. She noted increased awareness about her son, that he had so much to say and that he was so intelligent. She added that learning about both depression and ADHD was very helpful in understanding her symptoms as well as her son's behaviors. She noted that using problem-solving skills and parenting techniques to improve interactions at home and increase the children's positive behaviors was quite helpful. Finally, she had looked into after school activities for the children (karate and art programs) and had taken her daughter to visit her friend. Ms. Soto reported being quite satisfied with the intervention. This was clearly the beginning of an important process toward their sharing experiences together as a family. In response to their request, the preventionist assisted in helping the family to obtain further clinical services.

DISCUSSION

The results of this project suggest that the PIP was successfully adapted for use with an urban, Latino sample in the Boston area.

The results of this pilot study indicate that the L-PIP is not stressful, produces effects that are similar to those found in the original PIP investigations, results in a great deal of satisfaction among its participants, and can be taught to preventionists who are able to deliver the intervention with fidelity. Consistent with Rounsaville et al. (2001), these results underscore the importance of a return to a Stage I initiative when undertaking adaptation of established, efficacious preventive interventions for use with different populations. During postintervention interviews, the families described several characteristics of "acculturative stress" (Suarez-Morales et al., 2007), concerns about stresses arising from differences in language facility, the experience of discrimination, perceived difficulties in negotiating the host culture, and intergenerational conflicts that emanated from the clash between the parental culture of origin and their children's embrace of the host culture. Focus on these features of acculturative stress was a systematic part of the adaptation. Additionally, all of the mothers reported that there was nothing about their participation in the adapted intervention that was either hurtful or considered unhelpful. Of note, the mothers felt the intervention had increased their appreciation for each family member's perspective on the challenges confronting them.

The children reported feeling positive towards their experience in the preventive intervention, and particularly to better understand their depressed parent, however, the strength of their satisfaction was not as consistently strong as it was for their mothers. Whereas, the children had positive ratings on the postassessment self-report, they reported less change in communication between parent and child. This is to be expected as they were less the focus and only participated in two modules, one alone and one in the family meeting, as opposed to the mothers.

One of the most striking findings in this study was the strength of the therapeutic alliances for the mothers with the preventionists. The mothers' ratings of the therapeutic alliance were consistently at the upper range of the scale and were significantly higher than the positive alliance scores found in the effectiveness study for the original version of the preventive intervention (Beardslee et al., 1992). All preventionists were bilingual and bicultural professionals, which may have heightened the mothers' sense of feeling heard and understood, and therefore respected. Perceived similarities in values and language may have also contributed to increased trust (*confianza*) and stronger relationships. It is quite possible that this strong alliance fostered the positive response of the mothers towards the intervention (US Department of Health and Human Services, 1999), a speculation that warrants more systematic investigation in a subsequent clinical trial.

The postintervention interviews suggested a number of other issues germane to the adaptational process. First, parental depression was not the sole focus of the family during the modules. While the adapted intervention had a positive effect on the parents' perceived relationships with their children and enhanced family communication, there is little or no effect on those life circumstances that were beyond the scope of this intervention's purpose (e.g., financial worries, parental health concerns). They reported being better able to utilize parenting strategies that built upon the understanding of their children's strengths and/or learning difficulties, stages of de-

velopment, and ways to more effectively implement them through open communication and collaborative problem-solving. Second, there was an affirmation that, despite the presence of many adversities in their lives, these families were indeed resilient and that parents could contain the negative effects of their depression and continue to parent effectively. In that regard, the parents reported feeling better able to manage their depression since it was now open among family members and resulted in their being more comfortable requesting help. Third, the empowerment and benefits of open family communication were critical to their being able to sustain the changes that were being made. Family members consistently spoke about their “voices being heard” among themselves and how important it was to speak about what was previously unspoken regarding parental depression and other stressors impinging on them. Fourth, the flexibility of the adapted preventive intervention provided the families with increased information through psychoeducation about the range of issues that concerned them. This increased information extended beyond parental concerns to those of the children.

Clinical Implications from the Adaptation

Several important clinical implications emerged from the adaptation of the L-PIP:

1. Importance of the Family Meeting

The families in this project found the family meeting to be the most important aspect of the intervention. This meeting represented the culmination of previous conversations with each family member. The preventionists noted that some families also wanted to talk about additional concerns related to their day-to-day struggles. Boyd, Guy, and Bourjolly (2006) have reported that mothers raising children in multistressed environments preferred to tell their personal stories about what was salient in their day-to-day struggles of raising children in stressful environments with limited supports (e.g., isolation) and resources rather than focus on depression and parenting. For many families, this was the first time they were having a family conversation about difficult issues. Therefore it was more important that this dialogue be a positive experience. It was also important that the family decide which concerns were the most pressing and should be addressed during their meeting.

2. Recognition of Potential Difficulties in the Family Conversation

Consistent with the findings from other investigators who work with multigenerational Latino families (Lutz, 2006), a striking finding in our project was the degree to which some parents and children could not communicate in the same language beyond simple instrumental communication. For example, it was poignant when a 12-year-old adolescent in the middle of a family meeting responded to the request that she speak in Spanish so that her mother could understand her by saying, “*But I don’t know how to say how I feel in Spanish.*” While the role of the bilingual clinician in translating the language of feelings in the session was crucial, it was apparently even more important that this issue was openly identified and plans were made as to how it would be handled in the future.

We often found that the impact of the immigration experience and the demands on parents and, subsequently, their children in the process of adapting to a new culture were as misunderstood and as unspoken as was the parental depression (Suarez-Orozco & Suarez-Orozco, 1994). The preventionists functioned as cultural interpreters to help the family recognize conflicts between the demands of the minority and

majority culture (Zuniga, 1988). Some children felt either caught between two cultures or that their perceived realities were underappreciated in their parent's world (e.g., the efforts involved in preparing for college). The preventionists found that they played a crucial role in reducing these tensions by highlighting cultural strengths and in exploring creative solutions to these problems. Parent-child tensions arising from generational, contextual, or cultural invisibility could potentially block communication and the most important aspect of the intervention, that of having a successful family conversation.

3. Understanding Depression and Resilience

To fully understand the family's strengths and resilience in the face of parental depression, in this adaptation, it was important to learn the family's immigration/migration narrative, their hopes for that journey, and their current circumstances. In keeping with the centrality of "family and children" in Latino cultures, it was important to note the impact of family separation and the loss of support networks due to immigration as it related to parental depression.

One mother's immigration journey was experienced as treacherous yet necessary for economic survival. She made choices related to coming to this country and overcame obstacles. Obtaining her citizenship and raising her children here were the positive outcomes of her decision. This message was carried over to the conversations with the children; and her wish to stress the affirming aspects of her story, most importantly, the benefits of belonging to two cultures rather than the suffering she experienced. Her ties to family, especially her parents in the Dominican Republic, have remained close and she is able to travel back and forth with the children. Her children are bilingual and bicultural and can negotiate both worlds easily. Throughout the course of the intervention, the children began to understand their mother in a multidimensional way, not just as their parent, but as a daughter, sister, worker, and now, a US citizen. The narrative became one of triumph over adversity, rather than one of loss and heartbreak. She shared her hopes and dreams for them while stressing the economic realities, continuing to emphasize that in this country they could aim high.

Another mother had emigrated from South America at a young age. She had noted that after her mother's death, she had felt "frozen" and in coming to this country, had experienced hardship because of her husband's severe depression, job loss, and loss of home. In planning and holding the family meeting with her husband and son, she was able to recognize her own courage during tough times. She was able to see that she was the "trunk" (*tronco*) or strength for her family and the pillar that kept her family strong despite adversities.

It was also important to work with the metaphors that were used to describe the experience of depression. For example, another parent, debilitated by depression, found herself unable to function in general and particularly unsuccessful in finding her way to her children's school in her new community. She described her experience as "*feeling as if my wings have been cut.*" Helping this parent *reclaim her wings* became a metaphor to helping her reconnect with her sense of effectiveness by remembering a longer journey in finding her way to this country and all that it entailed. Since this parent, in describing her journey to this country as seeking a better future for her children and "*giving wings to her daughters,*" had kept her focus on resiliency, hope, and strength, we used her metaphors throughout the intervention to reinforce important points.

CONCLUSIONS AND RECOMMENDATIONS

In conclusion, it has been possible to modify this preventive intervention so that it is useful for recently immigrated Latino families while still remaining true to its core. In both this adaptation and in the work of Podorefsky et al. (2001), a family narrative that was shared and focused on strengths in overcoming depression and associated risk factors was an essential element. In our own view, the intervention was also enriched and transformed by this adaptation process.

There were some limitations present in this study and potential remedies that warrant consideration in future investigations. One area of further attention is the children's level of involvement in the intervention and its potential impact on their experience of it. First, for those children who truly were unaware of their mother's depression, the family discussion could be emotionally difficult. As such, it may be important to carefully consider whether this information is something that the participating children are truly aware of and further consider how to assist the depressed parents with the disclosure about this and related stressful issues as part of the family meeting process. Second, this study did not formally evaluate the nature of the alliance between the children and the preventionists. Whether further adaptation of the intervention is necessary to provide for additional attention to alliance formation with the children will await future investigation.

In future research and practice, greater attention needs to be directed to describing the process of adaptation and measuring the results. A neglected focus has been preventive intervention. We believe a strength based prevention focus was an essential component of the families being able to use this approach. Our work suggests that it is possible to bring a prevention perspective and that families welcome it. Following the observations of other investigators (Rogler, 1989), the process of adaptation was a continuous, intense process requiring considerable time and effort. It required weekly meetings over several years by the entire team for this work to be accomplished and we believe that similar commitments will be necessary for future successful adaptations of related approaches. Future attention in both treatment and research should be directed to exploring family centered, strength based preventions and evaluating their effectiveness in both Stage I and large scale randomized trials.

Future investigations of this line of research would likely benefit from increasing the number of families participating in a randomized trial, specifically measuring the degree of acculturative stress experienced by each of the families and/or its members, longitudinal follow-up to determine to what extent a reduction in risk of developing a depressive disorder actually occurred in the children, and an analysis of its effects on all family members, not limiting its focus on a particular child in the family. More generally, our experience convinces us that the conduct of a Stage I trial provides important and necessary data about the safety, feasibility, fidelity, and magnitude of effect for the later conduct of randomized clinical trials as well as for dissemination efforts.

As a final consideration, we grew to appreciate that the preventionist was in part an advocate for the family as the culture to which these families immigrated was both difficult and unfamiliar. More attention to the role of advocacy in working with families like these is needed. Nonetheless, perhaps most important in our work was a deep admiration for the strength of the families for the ways in which they found their voices to speak to one another and in their capacity to endure.

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