Group Cognitive-Behavioral Therapy for Depression in Spanish: Culture-Sensitive Manualized Treatment in Practice

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The authors applied cognitive-behavioral therapy (CBT) for depression using the Healthy Management of Reality treatment manual. This 16-week group treatment comprised four 4-week modules: thoughts (cognitive restructuring), activities (behavioral activation), people (interpersonal skills training), and health (addresses physical health and depression). They illustrated the use of the culture-sensitive treatment manuals by way of the member characteristics and clinical process of a Spanish-language CBT group for depression. They highlighted the challenges and satisfactions of working with a Spanish-speaking population in the public sector, and focused on how culture and socioeconomic status influence patients, and how to adapt treatment to these factors. Last, they demonstrated how technological advances integrate with culture-sensitive, evidence-based treatments to better serve this population and reduce disparities. © 2010 Wiley Periodicals, Inc. J Clin Psychol: In Session 66:1–11, 2010.

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The University of California, San Francisco (UCSF) Department of Psychiatry at San Francisco General Hospital (SFGH) serves a diverse population in terms of ethnicity and socioeconomic status. It is at the frontline of working toward the reduction of health disparities despite continued challenges, such as the recent economic downturn, which has resulted in several budget cuts and a reduction of

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services. Despite these difficulties, the hospital has utilized its relationship with UCSF to retain high-quality, evidence-based services. One example of continued provision of evidence-based services at SFGH is the routine use of the cognitive-behavioral Healthy Management of Reality (HMOR; Muñoz, 1996) treatment for depression in Spanish and English.

In this article, we will focus on a Spanish-language depression group as an example of culture-sensitive, evidence-based practice. We will describe the clinical population and treatment, illustrate a representative group as a case study, and discuss several directions for improving the efficacy and effectiveness of this treatment.

Group Cognitive-Behavioral Therapy (CBT) for Depression With Latinos

The Latino population is the largest (15%; 45 million) and fastest growing minority group in the United States (projected population of 133 million [29%] by 2050; United States Census, 2008; Pew Hispanic Center, 2010), with certain states about to become more than 50% Latino/a, such as New Mexico by 2015, Texas by 2025, and California by 2042 (U.S. Census Projections). More than 1 in 10 people in the United States over 5 years of age are Spanish speakers. Multiple reports highlight disparities in access to depression treatment among Latinos and other minority populations in the United States (Alegría et al., 2008). Because the impact of depression on Latinos has been well-documented (Aguilar-Gaxiola & Gullota, 2008), there is a need for innovative, evidence-based treatments for these populations to address existing disparities (Muñoz & Mendelson, 2005).

Psychosocial group depression treatment at SFGH uses the HMOR (Muñoz, 1996) treatment manuals. This CBT emphasizes the social environment, particularly how we learn from and influence our environments. The "influencing" piece is crucial as it relates to an individual's self-efficacy and sense of control in the world, and it serves as a key ingredient to improved outcomes in depression. HMOR translates Bandura's concept of reciprocal determinism (Bandura, 1977) into interventions designed to help recipients mold their day-to-day reality into a health-engendering, physical, social, and cognitive environment. This treatment, originally developed in the 1970s, is based on a behavioral approach to depression treatment with a focus on increasing response-contingent positive reinforcement in people's daily lives to improve mood (Lewinsohn; Muñoz, Youngren, & Zeiss, 1978; Zeiss, Lewinsohn, & Muñoz, 1979). It has been adapted for use at SFGH since the 1980s to prevent (Muñoz & Ying, 1993) and treat (Organista, Muñoz, & González, 1994) major depression and other disorders. The manualized treatment has been used to conduct research on the effectiveness of CBT in diverse, low-income populations that have often been ignored in rigorous efficacy and effectiveness studies (Muñoz & Mendelson, 2005).

The CBT group treatment manual (*Manual de Terapia de Grupo para el Tratamiento Cognitivo-Conductual de la Depresión*: *Aprendiendo a Manejar su Realidad Personal*; Muñoz, Ghosh Ippen, Rao, Le, & Dwyer, 2000) comprises four modules with four sessions in each module for a total of 16 weekly, 1.5-hour sessions. The "thoughts" module focuses on cognitive interventions, with a focus on awareness of thoughts and how they impact mood in positive and negative ways. This module is focused on individuals managing their "internal reality" that resides in their mind via thoughts and emotions. The "activities" module focuses on the importance of behavioral activation in improving depressive symptomatology, given

its important role in producing positive outcomes (Dimidjian, Hollon, Dobson, Schmaling, & Kohlenberg, 2006), as well as the simplicity of the message. The "people" module focuses on the impact of positive and negative social relationships on one's mood and depressive symptoms. The two latter modules address what we term "external reality" and encompass one's relationship with his or her environment. Last, the "health" module was developed and incorporated into the treatment to address our primary care population that has high levels of comorbid health problems.

Case Illustration

Group Composition

The group therapy is designed as a continuous group with rolling patient enrollment and changes in therapists over time. With a few lapses due to lack of Spanish-speaking providers or funding cuts, this group has been running since 1985, when the SFGH Depression Clinic was founded by Ricardo Muñoz, Jeanne Miranda, and Sergio Aguilar-Gaxiola. Patients are accepted each month, at the start of a new module, with each patient attending for all four modules, that is, 16 sessions.

In this article, we focus on patients in one 16-week period. The thoughts module began with five members, four new members joined the activities module, three new members joined the people module, and the health module included two new members, increasing the total group size to 14. Although 14 patients were officially part of the group, the maximum group size at any one period of time was 11 people, because some patients either attended only a couple of times and dropped out or had sporadic attendance. The age range of group members was between 37 and 74 years with a mean age of 50.5 years. As shown in Table 1, all of our group members were born in Latin American countries. Their number of years living in the United States ranged from 5 to 34 years, with a mean of 20 years. All of our group members reported having nuclear family members living outside of the United States, with four (29%) having children residing in their country of origin.

Several of our group members had lost their jobs within the past year because of medical reasons or economic conditions. Three of the 14 group members (20%) were employed part-time. Six group members had 10 years or more of education and two group members had completed some college. Group members represented a wide range of reading abilities. One group member was not able to read or write in Spanish or English, and only one of our group members was functionally bilingual. To address potential difficulties in comprehension, we emphasized the use of graphics in the treatment manual and throughout group sessions, along with culturally relevant sayings to convey core messages. These techniques are consistent with other successful interventions using multiple forms of culturally relevant media to help increase mental health literacy and self-efficacy (Lopez et al., 2009).

The most common Axis I diagnosis of group members was major depressive disorder, while others had different primary psychiatric disorders, all of which had a strong depressed mood component. As is often the case in community settings, group members had a variety of comorbid diagnoses as well (see Table 1). Regarding use of previous psychological services, five group members (36%) reported having received treatment prior to our group. Ten of the 14 group members (71%) were taking psychotropic medications (e.g., SSRIs for depression or anxiety). One group

Table 1
Demographic Characteristics of the Group

	n	%
Gender		
Male	4	29
Female	10	71
Country of birth		
Mexico	5	36
El Salvador	4	29
Nicaragua	2	14
Peru	2	14
Guatemala	1	7
Marital status		
Married	5	36
Living with someone	4	29
Single	2	14
Divorced	2	14
Widowed	1	7
Mental health diagnoses		
Major depressive disorder	7	50
Generalized anxiety disorder	6	43
Posttraumatic stress disorder	3	21
Adjustment disorder	1	7
Depressive disorder NOS	1	7
Panic disorder	1	7
Health problem		
Hypertension	7	50
Diabetes	5	36
Hyperlipidemia	4	29
Migraines	4	29
Asthma COPD	3	21
GERD	3	21
Hypothyroidism	2	14
Obesity	2	14
Syncope	2	14
Arthritis	1	7
Chronic pain	1	7
Fibromyalgia	1	7

Note. NOS = not otherwise specified.

member reported active/current suicidal ideation with a history of two lifetime suicide attempts. Another patient reported a history of passive suicidal ideation.

The patients in the group were referred by their primary care providers for management of mental disorders that accompany their chronic medical conditions. Depression can exacerbate chronic health conditions, including hypertension and diabetes, through mechanisms such as an increase in inflammatory proteins (Stewart, Rand, Muldoon, & Kamarck, 2009). Thus, our group included discussion of chronic disease management within the context of depressive symptoms. Group members were provided information about these relationships and were encouraged to share how their medical condition impacted their depressive symptoms and vice versa with a focus on the most applicable medical conditions as examples (see Table 1). For example, many patients commented on how managing their diabetes was similar to managing their mood, an analogy that we supported and built upon.

Case Formulation and Course of Treatment

We met weekly for 30 to 60 minutes to prepare before each group session. During those meetings, two or three (of the four to five) tasks were selected from the manual to present during group, depending on the patients' needs. The manual was designed to provide therapists with a menu of exercises from which to choose; therefore, not all the material included in each session of the manual was presented. We decided which cofacilitator would present content and generated ideas about how to discuss the material. Group leaders tracked patient progress via the Center for Epidemiological Studies-Depression scale (CES-D; Radloff, 1977), before every session, and with the Mood Screener for Depression (Muñoz, 1998) during the first session of each module. Suicidality was assessed throughout the course of the group in addition to completing the Mood Screener every 4 weeks (at the start of a new module), which includes items assessing for suicidality.

The group leaders also prepared a spreadsheet that summarized patient data and case formulation. Information was summarized under the following subheadings: sex, age, country of origin, medical diagnoses, suicide/violence risk level, special concerns (literacy, transportation, etc.), trauma history, psychiatric diagnoses, current psychotropic medications, and automatic thoughts. Throughout the treatment, we referenced the spreadsheet to increase our awareness of emergent themes and concerns that applied to individual patients as well as similarities across patients.

On the day before group, patients were contacted via telephone as a reminder to attend group, which patients stated was helpful. The first part of session included announcements and a quick review of the previous week's session. After a brief review of the session agenda, two group members presented their *proyecto personal* (personal project; i.e., homework), which entailed mood monitoring during the previous week. The task was renamed *proyecto personal* so as not to express the negative connotation associated with completion of homework in a school setting. During this exercise, coleaders highlighted the patients' endorsement of high and low points in their mood for the past week. We inquired about what events transpired for the patient, with an emphasis on the current module (e.g., cognitions, activities, interpersonal issues, and health) to make connections between mood and the themes of treatment.

In addition to reviewing the content for any given week, we employed several key strategies during each session. The HMOR instructor's manual highlights the four key strategies reviewed during each session: (a) presentation of the CBT model and rationale, (b) teaching specific mood management skills, (c) encouraging practice and application of skills in the patient's daily lives, and (d) attribution of positive change to a patient's use of the skills as a means to improve self-efficacy.

Using client-centered therapy methods (e.g., paraphrasing, reflection of feelings, summarizing), we employed the mindful development of rapport with patients, another key aspect of our group CBT treatment. Our incorporation of these methods served to increase the likelihood that group members would attend sessions and practice the self-control, mood management methods. Such methods also cultivate and maintain therapeutic alliance between patients and therapists, an element that predicts successful outcomes (Horvath, 2001).

Family. Most practitioners agree that delivery of mental health services should be consistent with the beliefs, values, and social conditions of those being served (Miranda, Azocar, Organista, Dwyer, & Arean, 2003). One of the key values that arose repeatedly during group sessions was the role of family. *Familism* has been

described as a core system of values centered on the family and is considered a commonality shared among a majority of Latino cultures. Familism is the strong identification and attachment of individuals with their families (nuclear and extended; Sabogal, Marin, Otero-Sabogal, & Marin, 1987). As Latinos immigrate to the United States and leave behind family members and larger social networks, their reliance on familial referents for behavior, attitudes, and social relationships may be significantly depleted, possibly leading to psychological distress.

Within the context of the group, our patients often discussed their relationships with family members living in the United States as well as their home countries. Family played a prominent role as a source of support, but also as a source of stress. Several of our patients had children living outside of the United States and shared with the group how difficult it was for them not to see their family members. One of our patients shared that speaking on the telephone with her children was "the only thing that keeps me going." Other group members discussed difficulty in managing intergenerational differences with their U.S.-born children. For example, one patient who is the mother of three daughters noted that she tries her best to emphasize getting an education with one of her daughters who is resistant to going to school. Another patient discussed how she experienced frustration and disappointment that she worked for years to support her 25-year-old son who was abusing alcohol and was unemployed.

Another theme related to familism that emerged across the 16-week treatment was the patients' discussion of family members who were deceased. Our group had three members whose sons had passed away during late adolescence and early adulthood. Two of our patients shared that their sons had been victims of gang violence, and they shared how this affected their depression as they struggled with guilt related to the events. These are examples of a prominent cultural value interacting with difficult socioeconomic circumstances in a new country.

Social cohesion and "simpatía". The notion of *simpatía* in Latino cultures suggests that individuals within the culture share in others' feelings while maintaining a dignity and respect toward others. This theme was highly present in the group members who provided and sought support from other group members. Accordingly, there is sometimes an emphasis on emotional responses that promote social relations instead of those reflective of the individuals' internal emotional experience. Because depression makes individuals less likely to engage in behaviors that promote social interaction or *simpatía* with others, social disconnection from others may be particularly distressing among members of a group that culturally values social connections. The salience of the effect of depression on social interactions made *simpatía* and social cohesion especially valuable themes that were promoted in session.

The people module takes on a particularly important role in highlighting how our social world influences our well-being. The group practiced *simpatía* and rapport building when new group members arrived at the beginning of new modules by introducing themselves to the group with a *presentación* (introduction). During the *presentación,*members shared personal information such as their family of origin, birthplace, and personal interests. By integrating *simpatía* into treatment, we targeted a culturally salient symptom of depression (isolation) by fostering each member's sense of belonging to the group.

Another example of group cohesion was observed during the final session for three members of the group. During the "graduation" from the group, those members

expressed their appreciation for the group leaders and members and requested other members' phone numbers so that they could arrange a celebration outside of the therapy setting. This example of group cohesion highlights the significance of social support within the context of a manualized group treatment and how we maintained this ingredient despite our adherence to the manual. We practiced flexibility within treatment fidelity.

To maintain positive social ties, a common thread among many immigrant patients is a level of deference and appreciation toward their psychotherapists, which appears generally higher compared with their U.S.-born counterparts (Organista & Muñoz, 1996). These patients tend to question the authority of therapists to a lesser degree. This last point is a double edged sword in that it improves compliance if people understand the material being presented, but it can backfire when individuals do not comprehend the purpose of therapy and continue to display agreement so as not to disrespect their therapists. Care must be taken to monitor patient's understanding and to intervene when there is evidence that a patient may not be benefitting because of lack of understanding or a fear of disrespecting an authority figure or professional.

In culturally adapting any treatment, one cannot employ a highly scripted approach that assumes that cultural values for a particular group are homogeneous. Cultural adaptation is a fluid process that must take into account what matters to patients, based on cultural context as well as what matters in their "local social worlds" (Kleinman, 1995). Although there are similarities in cultural values based on national origin, for example, these vary depending on economic, occupational, educational, or generational status. Religion or spirituality may provide a unique influence that is not shared by everyone from his or her ethnic background. Although it is imperative to understand how broad ethnocultural values influence behavior, it is equally crucial to assess how specific elements of one's social reality shapes attitudes and behaviors.

Outcomes and Prognosis

Studies of CBT with Latinos suggest a significant problem of treatment dropout. Organista et al. (1994) found a 58% dropout rate in a naturalistic study of the HMOR treatment in a low-income sample that comprised 44% Latino. In our group of 14 Latino patients, two attended only two sessions before discontinuing treatment. Among the patients who did attend more than two sessions, the group as a whole attended 60% of sessions with individual ranges of 31% to 100%. Reasons cited for not attending pertained to inclement weather, departure of a clinician midway through treatment, and a death in the family.

In addition to inconsistent attendance, adherence to completing the homework tasks was minimal. The weekly homework task comprised daily mood monitoring via a form in the participant manual. Of the seven average group attendees per week, only one to two actually completed the *proyecto personal* (homework) task in writing each day of the week. Although the manual includes additional optional tasks such as monitoring cognitions, behaviors, social contacts and health along with mood data, these were not completed by any group members because of difficulties completing the first step of mood tracking.

Although most patients did not complete their mood-monitoring task, we still asked group members to provide retrospective accounts of their mood. We find it important to not give up reinforcing completion of tasks, even if they are not done exactly as

instructed. When we reviewed the *proyecto personal* in each session, we typically reviewed two to three of the group members' mood ratings. We made it a point to include group members who had not completed the exercise by having them share their retrospective mood ratings, even though retrospective ratings are not ideal.

During treatment, we made efforts to track patients' symptomatology to ensure that we were intervening when an individual member's symptoms were not improving and reinforce positive change in others. Although we used the CES-D to monitor depressive symptoms for our group, we found that it did not always accurately reflect patients' reports of functioning when they presented in group or at the end of their treatment. For example, of three members that completed the first 16 weeks, only one participant showed a decline in CES-D score (1-point drop) compared with their first session. However, all three group members stated in their own words that they felt better than they did when they began treatment. For participants that had not yet completed their 16 weeks, there was an average 6.5-point drop from the first session to the 16th week. The inconsistency between the CES-D and clinical presentations caused us to question the validity of the measurements, perhaps because of misreading or miscomprehension. Thus, we began paying closer attention to assure that members understood measures, which may help explain drops in scores of newer members compared with original group members. We have also since replaced the CES-D and are attempting to use other measures that are shorter and, hopefully, more understandable such as the Patient Health Questionnaire-9. We are also planning to emphasize other factors such as patient's own assessment of their progress, which formal measures sometimes ignore but may provide valuable outcomes.

An example of progress was observed during the final session for three members who completed their 16-week treatment. During their goodbye to the group, they reinforced to other members the importance of attending group regularly, being on time, and practicing the skills taught in therapy. For example, one group member said, "if you don't practice these skills, you will fall back to a low place." Much to our satisfaction, they demonstrated a sense of efficacy and a command of the CBT model, while serving as examples for other members. The size of the group and the necessity of addressing treatment material in session often do not allow us as much time to devote to individual patients' concerns during group. However, the reactions of the outgoing group members reflected their ability to benefit and connect with the other group members despite our focus on the agenda. In sum, we believe (as do our patients) that there are two main curative ingredients in this treatment: the support of the group and the mood-management methods. The latter will probably have the longest impact because patients can learn to use them for the rest of their lives, while the group itself will end.

Clinical Practices and Summary

Decades of clinical experience and research evidence indicate that group CBT for depression is effective in preventing and treating depression in Latino-speaking and Spanish-speaking patients (Muñoz & Mendelson, 2005). Evidence-based practices can be culturally adapted in a successful manner that balances treatment fidelity and cultural sensitivity and yield positive outcomes for patients. Our group case study has highlighted examples of patients grasping the content of our treatment, applying it to their lives, and sharing it with other group members.

At the same time, more can be done to improve existing treatments. In particular, treatment adherence constitutes a major challenge in assuring maximum benefit for

patients. We believe that the positive impact of the group would increase if members (a) reviewed the CBT methods between sessions, (b) applied them in their day-to-day lives, and (c) completed the self-monitoring tasks focused on their mood, thoughts, and activities. To enhance adherence and increase the dosage of treatment, we are in the process of developing and testing two technological adjuncts to our CBT groups for depression: an Audio Coach and a mobile phone-based, text-messaging adjunct. We hope these adjuncts will reinforce the group treatment and skills beyond the therapy session.

The Audio Coach adjunct is particularly suited to address issues of low education and literacy in this population. For the Audio Coach adjunct (*El Consejero Portátil*), we have recorded brief (2–5 minute) audio files for each topic in each module. The audio files are uploaded onto mp3 players, and these portable and relatively inexpensive devices are used to provide audio reminders of the key messages taught in our CBT group: the rationale for the methods, how each method works, how to apply these methods in real life, and the importance of attributing change to the use of the methods, rather than to continued contact with the therapist or the therapy group.

For patients assigned to a waitlist before receiving treatment, the audio modules can introduce treatment principles before contact with their therapist. Standard evidence-based psychotherapy for depression typically comprises one weekly session for 12 to 20 weeks. The interval between sessions can be a relatively barren period, even in therapies in which homework is assigned, as in CBT. We believe that providing a ''bridge'' between sessions may increase efficacy of treatment without the burden of reading CBT materials. The use of the adjunct may allow patients to consolidate important information regarding treatment before, during, and after the CBT treatment is delivered.

We began usability testing the Audio Coach with 11 patients in a new depression group. Patients have responded well to the Audio Coach, using the mp3 player an average of three to five times per week. Some of the feedback we have received from patients is as follows: ''I don't like to read, so I listen to the *Consejero Portátil*,'' and ''I will use the Audio Coach and listen to it when I attend my dialysis appointments and wait for my treatment.'' Our goal is to disseminate the audio files via the Internet for other clinicians and Spanish speakers seeking treatment for depression. We hope that this simple and reusable resource may have the benefit of preventing or ameliorating depressed mood among those who are unlikely to seek traditional mental health services.

In addition, a text messaging adjunct (Txt4Mood) is in the pilot testing phase and is also aimed at improving treatment outcomes. The Txt4Mood adjunct is aimed at addressing problems with ''homework'' adherence during treatment by providing a convenient medium to track patient mood, cognitions, and behaviors. It is designed to work alongside the HMOR treatment in both Spanish and English. The automated system sends daily text messages to patients inquiring about mood ratings and additional daily messages that correspond to treatment themes. These messages include thought-tracking (both positive and negative), tracking of pleasant activities, tracking of positive and negative contacts, and tracking of physical well-being and illness. These messages are meant to reinforce skills, provide feedback to patients on progress, and help assess the effectiveness of the treatment. Additionally, patients receive reminders of weekly group meetings and patients on medication can also opt to receive reminders on their regimen. Another component of the system allows patients to reach out during difficult times by texting a keyword (e.g., STRESS) to receive a randomly generated message suggesting cognitive and behavioral tips to

counteract stressors and/or sad mood. They can also text the word HELP and receive the number for a suicide hotline or be prompted to contact 911 for an emergency.

Initial feedback from pilot testing of the Txt4Mood adjunct has been positive. For example, one user of the adjunct mentioned that it has been "nice to have someone checking in with me." Also, when given an opportunity to opt out of future messages, two individuals responded by specifically stating that they did not want to be removed, which is an initial indication that the adjunct is acceptable to patients. The rate of responses to messages has been considerably higher than what has been achieved with traditional paper and pencil methods.

Reports indicate particularly high use of mobile phones and text messaging among Latinos with 85% owning a phone and 75% of those already using text messaging (FCC, 2010). Given the accessibility of mobile phones and their relatively low costs, more people can benefit from health treatments. Although our focus is depression, these tools can inform the development of other health interventions. We see these low-cost tools as providing higher quality care and, thus, helping to reduce health disparities among low-income and ethnic minority populations. These initiatives are part of our mission to employ evidence-based, technology-aided, culture-sensitive treatments to reduce health disparities worldwide, that is, to "think globally, act locally, and share globally" (Muñoz, in press).

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