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BRIEF REPORT

Adapted Cognitive Behavioral Group Therapy for Depressed Low-Income African American Women

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ABSTRACT: In this study we examine the degree to which a manualized cognitive-behavioral therapy intervention can be adapted to be culturally sensitive in treating depressed low-income African American women with multiple stressors. We describe the adaptations we made to an existing intervention, a group treatment developed for depressed low-income medical patients. We also describe our evaluation of the adapted treatment in which outcomes of African American women treated in the culturally adapted group were compared to African American women treated in the non-adapted group. Following treatment, women in the adapted group exhibited a larger drop in average BDI scores. Implications are discussed in terms of challenges related to the development and evaluation of culturally adapted treatment.

KEY WORDS: cognitive-behavioral; therapy; African American; depression.

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As clinical science moves toward standardizing and validating treatment approaches, relatively little is known about the efficacy and validity of treatment approaches across diverse populations (Bernal & Scharro-del-Rio, 2001). This information is important given the underutilization of mental health treatment by ethnic minorities in this country (Neighbors, Bashur, Price, Selig, Donabedian, & Shannon, 1992; Snowden, 1999; Sue, 1988). While under-utilization could be related to a variety of issues, some discussion has centered on the lack of ethnically accessible and compatible treatment. Culturally adapted therapy approaches may be more compatible with ethnic minority patients' cultural experiences in comparison to standard treatment, and therefore may better at treating psychological distress.

In this article we present details related to changes in the structure and content of therapy for depressed African American women, as well as preliminary attempts to determine the effectiveness of the adapted treatment approach in comparison to non-adapted therapy. Modifications are based on therapy techniques or content that either indirectly or directly address specific aspects of the African American cultural experience as part of the overall therapeutic tasks (McNair, 1996; Randall, 1994). We hypothesized that our adapted treatment approach would result in decreased symptom intensity in comparison to non-adapted treatment.

DESCRIPTION OF INTERVENTION

Our adapted intervention is a modification of a manualized cognitive-behavioral group treatment protocol for depression developed by Muñoz and Miranda (1986) at the Depression Clinic at San Francisco General Hospital. This treatment (CBT) consists of three four-session cognitive-behavioral modules. After completing each of the three modules patients repeat the first module for a total of 16 sessions. These modules focus on cognitions, activities, and relationships and were based on cognitive-behavioral treatment for depression described by Lewinsohn and colleagues (Lewinsohn, Muñoz, Youngren, & Zeiss, 1986) and adapted for minority primary care patients by Muñoz (Muñoz & Ying, 1993, Muñoz, Ying, Bernal, Pérez-Stable, Sorensen, Hargreaves, Miranda & Miller, 1995; Muñoz, 1997). In the CBT intervention patients are given a manual with outlines of each session and weekly homework assignments. New patients are introduced in ongoing groups at the beginning of each four-week module. Successful use of this intervention with a low-income,

ethnically diverse population of general medical patients has been described elsewhere (Organista, Muñoz & Gonzalez, 1994).

Our culturally adapted treatment (Kohn & Oden, 1997) or AACBT, is based on several changes to the existing CBT intervention using a variety of sources including theoretical literature, published descriptions of treatment approaches used with African American women, and consultation with therapists who have experience treating African American women. The adaptations are both structural and didactic. Structural adaptations refer to changes in the structure and process of therapy. Didactic adaptations refer to changes in the content of the material to be covered each week.

Structural adaptations include; 1) limiting the group to African American women, any age, with a diagnosis of Major Depressive Disorder, 2) keeping the group closed to facilitate cohesion, 3) adding experiential meditative exercises during treatment and a termination ritual at the end of the 16-week intervention and 4) changes in some of the language used to describe cognitive-behavioral techniques (Randall, 1994). For example, rather than using the term "homework" the group members were asked for suggestions and agreed upon a preferred term "therapeutic exercises." Whenever possible, African American individuals and anecdotes from African American literature were used as examples to illustrate concepts.

Didactic adaptations to the material consist of four culturally specific sections of content that are added as therapy modules. A summary of these modules is presented in Table 1. They include; 1) creating healthy relationships (Boyd-Franklin, 1987; Greene, 1992; McCombs, 1986) 2) spirituality (Ellison, 1995) 3) African American family issues (Boyd-Franklin, 1987), and 4) African American female identity (Boyd-Franklin, 1991; Greene, 1992; Mays, 1986, Neal & Wilson, 1989). These adaptations represent our attempt to contextualize the therapy manual to address issues relevant to African American women in treatment for depression.

EVALUATION

Participants

Participants were general medical patients referred to the outpatient Depression Clinic (Division of Psychosocial Medicine) at San Francisco General Hospital by their primary care doctor. African American female

TABLE 1

Didactic Adaptations/Culturally Specific Therapy Modules

Topic	*Purpose/Description*	*Exercises*
1. Healthy Relationships	Combat social isolation Deconstruct 'Black Superwoman' Myth	Practice trust with group disclosure exercise.
2. Spirituality-Religiosity	Non-denominational exploration of faith-based coping strategies	Share practices with group. Incorporate practices at home.
3. African American Family Issues	Identify generational patterns of behavior Reinforce Black families' history of strength	Construct and present family genogram (2–3 generations).
4. African American Female Identity	Discuss and combat negative images Acknowledge/Affirm Black women	Choose role models. Identity Affirmation contracts.

patients who met criteria for major depressive disorder were offered the choice of cognitive-behavioral group therapy (CBT) or an adapted cognitive-behavioral treatment group for African American women (AACBT). Approximately 83% of these patients (10/12) opted for treatment in the AABCT group. One woman preferred individual to group treatment and another preferred to be treated in the CBT group. Of the ten African American women who agreed to enter the AACBT group, eight completed therapy and were compared to ten demographically matched (race, age, education, income, diagnosis, referral source) women who had been previously treated in the CBT group.

The majority of women were middle-aged (average age = 47 years), high school graduates and unemployed. Half of the sample met criteria for more than one psychiatric disorder (most commonly substance abuse in remission, anxiety, PTSD). The majority of women had one or more chronic medical conditions (most commonly diabetes, arthritis, asthma, and hypertension). Both groups of women received treatment for non-psychiatric medical conditions at the General Medicine Clinic of the

hospital. All of the women in both groups had received an Axis IV (psychosocial stressors) diagnosis, most commonly 'economic strain' or 'family-related problems.' The average Global Assessment of Functioning (Axis V) score was 54. For the majority of women in both groups, the group therapy treatment was their first experience in ongoing psychotherapy.

Measures

The Beck Depression Inventory (BDI) (Beck, Ward, Mendelson, Mock & Erbaugh, 1961) was used to assess the level of symptom intensity during the first and last weeks of treatment. BDI categories include severely depressed (>25), moderately depressed (16–24), and mildly depressed (10–15) (Beck, et al., 1961). Scores of less than 10 are commonly considered 'not depressed.' AACBT group sessions were videotaped and coded for two constructs; 1) predominant themes initiated and discussed by participants and 2) the affect/emotional tone of treatment sessions.

Treatment

Treatment in both AACBT and CBT interventions consists of 16 weekly, 90-minute group therapy sessions. Both interventions are manual-driven with weekly didactic content and in-group exercises, as well as weekly homework assignments designed to reinforce the therapeutic material. While the CBT group permits rolling admission with new patients starting at the beginning of each of the three modules, the AACBT group is a closed group with the same patients beginning and finishing the group at the same time.

RESULTS

As can be seen in Table 2, women in both the CBT and AACBT groups exhibited pre-treatment BDI scores in the severe range. Women in the AACBT group exhibited a slightly higher initial average BDI score (34.4) than women in the CBT group (30.3). In terms of post-treatment improvement, both groups evidenced a drop in symptom intensity based on average BDI scores in the last week of treatment. The average final BDI score for both groups was in the moderate range (23.1). The AACBT group's average BDI scores decreased 12.6 points from pre- to post-

TABLE 2

Pre- and Post-Treatment Depressive Symptom Intensity Based on Beck Depressive Inventory (BDI) Scores

BDI Scores	*AACBT Group (n = 8)*	*CBT Group (n = 10)*	*Average BDI scores in Both Groups*
Pre-Treatment BDI	34.4	30.3	32.3
Post-Treatment BDI	21.8	24.4	23.1
Average Decrease	–12.6	–5.9	–9.2

Note: BDI scores can range from 0–60.

treatment (average final BDI = 21.8) in comparison to a decrease of 5.9 points in the CBT group (average final BDI = 24.4).

Research assistants were trained to code the 90-minute therapy sessions for thematic content and affective tone. Coders analyzed videotapes of each AACBT group session in 15-minute blocks to capture changes in content and affect. Suicidal ideation, substance abuse of significant others, racism experienced in social services, social isolation, and caretaking of family members were the predominant themes initiated by participants. In addition, the predominant affective tone of the sessions was identified as intense irritability rather than sad or dysthymic mood. The affective tone appeared to be generalized and not solely based on one or two strongly expressive group members. This finding is consistent with the experience of the group co-leaders who experienced the group as much more energetic than other depression groups.

DISCUSSION

Overall, the African American women in the AACBT and CBT groups demonstrated higher initial BDI scores than reported by a meta-analytic review of CBT outcomes for depression treatment across 28 studies (Nietzel, Russell, Hemmings, and Gretter, 1987) and a study conducted with patients similar to those described here (Organista et al., 1994). Thus, it may be that low-income African American women wait to come to treatment until their depression is more intense, as evidenced by higher depression scores. Future reports from clinical trials that include African American women should give information about this possibility.

In Nietzel's meta-analysis, with a predominantly White, middle class population ($n = 28$ studies), the post-treatment BDI score was 12; in Organista's outcome study (1994), with a predominantly low-income, public sector population ($n = 70$), the post-treatment BDI score was 18.0. For low-income, African American women, the post-treatment score was 21.8 in the AACBT condition ($n = 8$) and 24.4 in the regular CBT condition ($n = 10$). This suggests that CBT for depression may work best in the population for which it was developed, and becomes less effective as groups differ.

This pilot evaluation conducted found that, on average, symptom intensity was alleviated by approximately the same 9+-point margin reported in the Organista study. Women in the culturally adapted (AACBT) group exhibited alleviation of twice the magnitude (12.6) of women in the usual (CBT) treatment group (5.9). Nevertheless, both groups continued to evidence scores suggesting a need for further treatment. African Americans may score high on symptom intensity measures without exhibiting corresponding high prevalence rates of depression (Vega & Rumbaut, 1991). Based on coding of videotaped sessions, the predominant affective expression appeared to be irritability rather than sadness. Therefore, despite evidence that the syndrome of depression is recognizable across cultural groups, differences in the manifestation of symptoms may exist (Brown, Schulberg & Madonia, 1996).

This pilot evaluation is based on a small sample size. The women in the AACBT group are not representative of a larger distribution of African American women in that they are extremely poor, mostly unemployed and suffering from chronic and debilitating medical conditions and stressful social conditions. However, we provide direction to investigators interested in studying ethnic variability in treatment outcomes and the effectiveness of treatments adapted for use with specific populations. Despite calls for cultural competence in treatment, systematic investigations of the effectiveness of culturally adapted interventions do not exist. We have raised several issues we believe deserve attention, as the field becomes increasingly sophisticated and specific regarding mental health services. With the current climate demanding evidence for efficacy and effectiveness of treatment approaches, it is important to understand the kinds of interventions that work for specific populations.

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