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A Cognitive-Behavioral Group Therapy Intervention With Depressed Spanish-Speaking Mexican Women Living in an Emerging Immigrant Community in the United States

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This article reports feasibility issues with the implementation of an intervention study for depression in Latina women from Mexico living in an emerging immigrant community in the United States. Based on the PRECEDE-PROCEED model, the study explores implementation issues such as the intervention and retention, logistical issues such as transportation and childcare, and possible measurement issues such as reliability and validity of the Center for Epidemiologic Studies–Depression Scale, Spanish version. Future studies should evaluate the Center for Epidemiologic Studies–Depression Scale, Spanish version, and test the modified cognitive-behavioral group therapy intervention in larger samples and through randomized controlled studies. **Key words:** *cognitive-behavioral group therapy*, *community-based research*, *depression*, *Latinas*, *Mexican women*

LATINOS currently account for 15% of the US population[1] and will constitute 24.4% of the population by 2050.[1] The Latino population is growing most rapidly in nontraditional, nongateway states such as North Carolina. Most of the Latinos in these emerging communities are foreign-born and nearly three quarters (73%) are Mexican.[2] A *Latino community* is defined as "emerging" if the overall local Latino population in 1980 was less than 8% (the national US Latino population percentage in the 1980 US census), and the local Latino community grew by more than 145% (the national growth rate for the US Latino population between the 1980 and 2000 US censuses) between 1980 and 2000.[3] Not surprisingly, the experiences and needs of Mexican Latinos in this new diaspora differ from those of the Latinos in traditional centers of immigration with well-established Latino communities.[4-6] Emerging Latino communities, for example, are less likely to have social services staffed by bilingual or bicultural

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individuals or both (medical facilities, schools, and mental health centers), and they tend to have a smaller Latino social infrastructure (stores that stock Latin American food staples, religious services presented in Spanish, Latino cultural festivals, access to a variety of Spanish media, and small businesses that cater to Latino clientele). These factors contribute to adjustment issues and health problems in these communities.[5,6]

As a group, Latinos in the United States experience more depression than whites and African Americans, but Latinos receive fewer mental health services than other groups.[7,8] In a study of care for depression and anxiety disorders, Young et al[9] found that the rate of appropriate mental healthcare for Latinos was only 24%. Latinas, in particular, report poorer mental health and less experience with mental health services than their white and African American peers.[10] (For a full review of factors that contribute to depression in Mexican women living in the United States, see Shattell et al.[11]) The Institute of Medicine, Centers for Disease Control and Prevention, the National Institute of Mental Health/National Institutes of Health, and the Department of Health and Human Services and Healthy People 2010 have all identified a need to address mental health care for Latinas.[7]

A large body of research and several meta-analyses[12–16] have been completed to examine the effectiveness of cognitive-behavioral therapy (CBT) on depression.[12] Many of these studies have revealed that CBT is an effective method for treating symptoms of depression, and CBT is as effective or more effective in treating depression than alternative treatment methods, including medications.[12–15] The CBT appears to be equally beneficial for men and women.[17] In an extensive meta-analysis of 48 studies, Gloaguen et al[15] concluded that CBT was more effectual in treating mild to moderate levels of depression than antidepressants, wait listing, or other treatment methods. More recently, DeRubeis et al[18] found that cognitive therapy was as successful in treating moderate to severe depression as antidepressant medication, and more effective than placebo. Most impressively, Hollon et al[19] reported that 12 months after receiving CBT, patients who responded well to CBT were no more likely to experience symptoms of depression than patients who were currently taking antidepressants, and less likely to relapse than patients who had discontinued medication treatments. Along with individual treatment, CBT group interventions have been found to be valuable in treating depression.[20]

STUDY PURPOSE

Building on the preliminary work of a community-based participatory research team,[21,22] this interdisciplinary team of nurses, counselors, educators, public health educators, social workers, and pastoral care providers explored the feasibility of conducting an 8-week cognitive-behavioral group therapy (CBGT) intervention[23] with depressed Spanish-speaking women of Mexican origin who lived in an emerging immigrant community in the United States.

THEORETICAL FRAMEWORK

Green and Kreuter's[24] PRECEDE-PROCEED model for health promotion served as the conceptual framework for this feasibility study. The overall goal of health programs and interventions using the PRECEDE-PROCEED model is to enhance the quality of life of individuals or target populations or both. This is consistent with the goal of this feasibility study, to contribute to research designed to improve the mental health of Mexican women residing in the United States. One of the cornerstones of the PRECEDE-PROCEED model is that health programs are "a set of planned and organized activities carried out over time to accomplish specific health-related goals and objectives."[24(p1)]

This research team conducted a study earlier that focused on the "epidemiological

assessment" stage in the PRECEDE phase of the PRECEDE-PROCEED model.[24] In that study,[21] we asked a convenience sample of Latina women from our community to provide their perspectives on environmental factors that impact their mental health, as well as their behaviors and coping strategies for dealing with mental health issues. According to Green and Kreuter,[24] it is crucial to gather information directly from those who will be served by a health program in order to increase participation and follow-through by the target population. In our previous study, we found that depression was a concern of Latina women in the community, and the population was interested in receiving mental health treatment and education from mental health professionals.[21] Most of the women in that study believed that professional help for mental health issues was superior to help from promotoras, who are lay health or community health workers.[21] This step in the PRECEDE-PROCEED model was imperative, considering that the findings from our previous study[21] disputed the research team members' original suppositions that promotoras or lay health advisors might be preferred conduits of mental health treatment. Following the findings of the PRECEDE stage of our process, the current feasibility study of a CBGT intervention for depressed Mexican women begins the PROCEED phase of the model, acting on information gathered from the target population.

The intervention implemented in this study was considered a health program since it addressed the mental health and well-being of participants. Specifically, it was a psychoeducational counseling group where the primary goal was to encourage participants to process their community experiences and to be taught methods to better cope with stressors through CBGT techniques. The secondary goals of this study were to examine the intervention in hopes of developing more appropriate and culturally relevant group counseling experiences for Mexican women in emerging Latino communities and for researchers to gain process-oriented information about this type of research with this population.

The implementation of the intervention in this article will be reported according to a modified version of the community collaboration model derived from the PRECEDE-PROCEED theoretical framework that was developed by Watson et al.[25] Watson et al[25] used a process-oriented community-based participatory research approach. We modified the model to assess the feasibility of conducting a CBGT intervention study among Mexican women living in an emerging Latino community in the United States. See Table 1 for a visual representation of how we used the Watson et al model for this study. The university's institutional review board approved the study.

Implementation of the intervention followed 6 aims: (1) to identify Mexican women who were at risk for depression; (2) to identify the logistical needs of Mexican women with regard to participation in a research study requiring participation in weekly group therapy; (3) to strategize with community collaborators about the best approach to facilitate attendance in group therapy sessions; (4) to implement the group therapy intervention; (5) to review and analyze the intervention, which included identification of what worked well, along with barriers and future needs; and (6) to develop implications. The sixth aim included disseminating information from the feasibility study and using those findings to plan future implementations of the CBGT intervention for Mexican women living in emerging immigrant communities.

IMPLEMENTATION

The first aim: Identify Latinas at risk for depression

From a previous study by this community-based participatory research team,[21] depression in Latina women was identified as a concern. Mexican women are the largest Latina subgroup in the local community where this study was conducted. Through frequent contact in their community programs, the

Table 1. Watson et al model and study aims

	Watson et al Community Collaboration Model based on PRECEDE-PROCEED framework and community-based participatory research methods	Shattell et al feasibility study
Aim 1	Establish networks and links with community groups	Identify Latinas at risk for depression
Aim 2	Figure out health needs of the community and gaps in access to healthcare using focus groups, interviews, and forums	Identify logistical needs regarding participation in the study
Aim 3	With the community, determine best strategy to address gaps	Strategize with community members to facilitate attendance
Aim 4	Put the strategy into action	Implement the intervention
Aim 5	Review how things worked and make changes as needed	Evaluate the intervention
Aim 6	Share the results with the community and with our decision makers	Implications and dissemination

community collaborators knew potential participants who they believed experienced depressive symptoms and were likely to participate in this feasibility study. To solicit interest, these community collaborators privately discussed the study with potential participants and explained the purpose of the study as well as expectations of participants. Mexican women who were likely to participate then talked with trained, Spanish-speaking graduate research assistants (group facilitators; Ivers and Mails are bilingual but not bicultural) who further explained the study, evaluated participants' depression (using the Spanish version of the Center for Epidemiologic Studies–Depression scale [CES-D]), and ensured that participants met the study's inclusion criteria (self-identified as a woman, 18 years or older, scoring 16 or higher on the CES-D scale, and born in Mexico).

Assessing depression

To measure the presence of depressive symptoms before the intervention was initiated, potential participants were assessed using the Spanish version of the CES-D. The CES-D has been used for 30 years, with a reported internal consistency of .85 to .90.[26] The Stanford Patient Education Research Center reported good internal consistency reliability of .90 for 20 items and .92 for 18 items of the Spanish CES-D and strong test-retest reliability of .93 for 20 items and .92 for 18 items when it was tested on 272 Spanish-speaking individuals,[27] while Bonilla et al[28] found a .70 correlation with the Beck Depression Inventory.

The possible range of scores on the CES-D is 0 to 60, with higher scores indicating more depressive symptoms.[27] Scores greater than 16 are indicative of high risk for depression.[27,28] Therefore, only Mexican women who scored 16 or higher on the preintervention CES-D were included in the study.

The pre- and posttest CES-D was offered over the phone by one of the facilitators. The facilitator called each participant, identified herself, and explained that the questions were part of the group for depression. The facilitator read the directions and then read each question carefully. Each participant answered each question without hesitation, requiring less than 5 minutes to complete the measurement. The Spanish CES-D also was administered before the fourth session began, and was completed with pencil and paper by each participant. Participants, all proficient readers

in Spanish, were able to complete the measurement in approximately 5 minutes.

Sample

Based on previous studies with group counseling interventions,[29,30] as well as recommended standards of group counseling practice,[31] the desirable group size for this type of intervention is between 6 and 8 participants. Because of limits in funding as well as availability of bilingual group leaders, only 1 group intervention could be piloted for this feasibility study.

The convenience sample included 6 participants between 26 and 38 years of age ($M = 30$). The length of their residence in the United States ranged between 3 and 10 years ($M = 5.6$ years). When asked, "Why did you come to the US," 2 participants replied "for work," 2 replied "for a better life," 1 replied "for work and a better life," and 1 left the question blank. All participants had between 2 and 3 (mode = 3) children who were between 6 months and 13 years of age ($M = 4.5$ years). None were employed outside the home. Spanish was each participant's primary language. Five participants rated their English proficiency as "beginning or little," and the sixth woman did not report her English proficiency. Information on immigration status was not collected.

The second aim: Identify logistical needs regarding participation in the study

The second aim was to identify the logistical needs of Mexican women with regard to participation in a research study requiring weekly participation in an 8-week group therapy intervention. On the basis of findings from our previous study in the PRECEDE stage of the theoretical model, and our knowledge of the community, we anticipated that transportation would be a logistical issue. Aside from lack of access to an automobile or adequate public transportation, legal issues and fear of deportation were found to be barriers to transportation in our previous research.[21] In North Carolina, the US state where this study was conducted, persons who are undocumented cannot obtain a driver's license. As a result, some undocumented immigrants were fearful to drive because even a minor traffic violation, or involvement in a traffic accident caused by someone else, could bring the attention of the local law enforcement agency and could lead to detention or deportation. Deportation would separate them from their children. Although legal status of this study's participants was unknown, we believed that providing transportation to and from the intervention was essential.

Coordinating transportation for research participants was not simple. Routes needed to be mapped for volunteer drivers to pick up the participants who lived in rural areas of the county. Careful and clear directions to participants' homes were essential. Most of the women lived at a considerable distance from one another, which required dividing the "route" to expedite transportation. In addition, plans needed to be made for car seats, which required extra space in the vehicles. Large vehicles were required to accommodate drivers, participants, participants' children, and car seats. This was learned after one of the drivers tried using a minivan to transport 2 participants and their children, but the minivan was not large enough to accommodate them, the required car seats, and the driver. It was helpful when the drivers were bilingual (Spanish and English). Based on the findings from the PRECEDE study, childcare was anticipated to be another logistical issue. Most of the participants had young children. Weekly attendance was facilitated by providing childcare for participants' non–school-aged children (younger than 5 years) at no cost to them. Undergraduate, prelicensure nursing students provided the childcare. As nursing students, they were CPR certified and had satisfied the required immunizations, criminal background checks, and health records. The childcare workers who were hired spoke only English, which made verbal communication somewhat difficult with some of the older children. In the future, hiring bilingual or

Spanish-speaking childcare providers is recommended.

Nevertheless, there were times when children joined their mothers in the sessions. One participant's toddler remained with his mother during each session. While this concerned the facilitators, they recognized that this enabled the participant to remain in the group. The other group members agreed to allow the child to be present in the room.

The third aim: Strategize with community members to facilitate attendance (Retention)

The third aim was to strategize with community collaborators on the best ways to facilitate attendance in the group therapy sessions. The community collaborators confirmed that transportation and free childcare were essential. In addition, to enhance participation and retention in this feasibility study, the community collaborators and academic researchers chose to use incentives. Since the items needed to be an inducement but not coercive, participants received a $10.00 gift card for each group therapy session they attended until the last session (each session lasted between 60 and 90 minutes). During the last session, they received a $25 gift card to compensate them for the extra time required to complete the study tool. The amount of time that each participant spent each week of the intervention varied from 2 hours to 4 hours, which accounts for travel time to the session, the group therapy session, and then transportation home after the group therapy session. Therefore, the research team did not believe that $10 per session (for weeks 1 through 7) and $25 (for week 8) was coercive. After a full discussion among the research team and community collaborators about the possible problem with coercion, they agreed upon these amounts. The community collaborators chose the store (a large discount store) for the gift cards.

A group facilitator or a bilingual transportation volunteer called participants the day before each intervention to remind participants of the group therapy session and to confirm transportation and childcare needs. These phone calls may have enhanced attendance.

Only 1 woman did not complete the 8-week program. This participant withdrew after the first week of the intervention to take an English-as-a-second-language class that was scheduled at the same time as the group therapy intervention.

The fourth aim: Implement intervention

Interventionists (Group Facilitators)

Hendrix et al[32] support the use of cotherapy teams. The 2 interventionists (cogroup facilitators) for this study were mental health care professionals and graduate students. One facilitator was an intern in her fourth semester of a master's program in counseling (Mails). At the time of the intervention, she had completed the majority of her clinical coursework, including diagnosis and treatment planning and group counseling. She had worked with several clients who suffered with depression. Though not a native Spanish speaker, this bilingual facilitator majored in Spanish as an undergraduate student.

The other facilitator had a master's degree in counseling and was completing his fourth semester of doctoral training in counseling and counselor education (Ivers). While not a native Spanish speaker, this facilitator lived in Panama for 2 years. He had experience providing counseling to Spanish-speaking clients, many of whom immigrated to the United States from Mexico and suffered with depression. Before participating in this intervention, he had experience facilitating and cofacilitating several counseling groups. Both facilitators (Ivers and Mails) received clinical supervision throughout the duration of the intervention period.

Intervention

The fourth aim was to implement the study group therapy intervention incorporating strategies from aim 3, while remaining aware that additional measures may be

necessary. Bilingual and bicultural community collaborators who were mental health service providers reviewed and approved the intervention before implementing it.

The intervention used was the 1996 Muñoz and Miranda Group Therapy for Cognitive-Behavioral Treatment of Depression, Spanish version.[33] (The complete intervention manual is available free as a PDF file from the following Web site: http://www.rand.org/pubs/monograph_reports/MR1198.4/.) This intervention was initially developed in 1986 to meet the needs of low-income, minority individuals with depression, who lived in densely populated urban Latino communities. The communities in which the intervention had been implemented were all established Latino communities, in that a significant Latino population (greater than 8%, which was the US Latino national average in 1980) was present, and the local Latino population showed slow growth (less than the 145% growth in the US Latino national average between 1980 and 2000) due to the sheer size of the historical Latino community.[3] Topics discussed in the original intervention focused on cognitions, behaviors, interpersonal relationships, and the relationship between general health and depression.

The 1986 intervention included 12 sessions (lasting 90–120 minutes) and was intended for both men and women.[34] The intervention was divided into 3 modules focusing on the relationships between depression and thoughts, activities, and people. This original version of the CBT group intervention proved effective in minimizing depression and depressive symptoms in clinically depressed Latino men and women.[35,36] Similar results were reported in a subsequent study, using the same intervention with African American women.[37]

Muñoz and Miranda[33] then developed an 8-session revised version of the intervention that targeted low-income minority women. Although the revised intervention was divided into the same 3 modules, more sessions were devoted to the relationship between depression and thoughts (4 in total) than to the relationship between depression and activities and people (2 sessions per module). The 1996 version has proved effective in minimizing the impact of depression, particularly among low-income minority women.[34,38] The study reported here used the 8-week 1996 version of the intervention.[33] See Table 2 for an outline of the sessions and topics.

Table 2. General schedule for the intervention

Session no.	Topics covered
1–4	Discussed the relationship between thoughts and mood Gave participants homework targeting the recognition and modification of negative thoughts
5–6	Discussed the relationship between activities and mood Processed with group members activities associated with ways to improve mood Helped participants develop individual goals associated with their behavior patterns
7–8	Discussed the relationship between contact with other people (eg, friends, family) and mood Processed with the group ways in which they could improve their contact with other people

Participants in this intervention attended weekly 60- to 90-minute group therapy sessions led by trained bilingual group facilitators (Ivers and Mails) that consisted of verbal discussions about depression, consistent with the Muñoz and Miranda intervention.[33] The setting for the intervention was a counseling clinic at the authors' institution. This clinic was selected, in part, because it provided a room adequate to offer the intervention. In addition, the clinic and university are centrally located in the community, again facilitating access for participants. Finally, the

clinic provided 2 separate "play rooms" for the childcare activities, adjacent to the room where the intervention took place.

The fifth aim: Evaluation

The fifth aim required a review and analysis of the study intervention. This included identification of what worked well along with barriers and future needs. Feedback about the intervention from participants and researchers was reviewed and analyzed. Themes from the group therapy discussions were described as they related to the content and process of the intervention.

Preintervention CES-D scores ranged from 16 to 44 ($M = 30.67$; SD = 11.59) and postintervention scores ranged from 10 to 40 ($M = 22.33$; SD = 15.69). The sample was too small for inferential statistics to be meaningful. We cannot determine whether the intervention was effective at decreasing participants' depression symptoms, nor can we address potential moderating or mediating effects such as acculturation or assimilation (since we had not measured or collected this information). Regarding measures of depression alone, some participants scored higher (indicating greater depressive symptoms) on their postintervention CES-D than on their preintervention CES-D. Further study is needed. This research team is planning a follow-up study with these participants to discuss their depressive symptoms and the intervention.

Nguyen[46] observed that there is some concern about the validity of the Spanish language CES-D and noted that the concept of depression might not be the same among Latinos. Some items considered important for depression in whites may not have meaning to Latinos, while concepts important to the Latino meaning of depression may not be included. Furthermore, the meanings of words may differ, and perceived stigma may influence responses. While these were acknowledged to be potential problems, no Spanish-language depression measurement tool with better reliability and validity was found. Of note, there were no problems associated with completing the measurement tool (CES-D). Participants seemed to understand the questions and they had no complaints about the time it took to complete the tool.

Consistent with the PRECEDE-PROCEED model, the group facilitators modified the original intervention to meet the needs of these participants. These modifications enhanced the usefulness of the intervention in this population. Revisions of the 8-week intervention made for this study included reducing the number of weekly in-group worksheets and at-home assignments, while increasing time for group and interpersonal processing. Since none of the participants had experience with CBT concepts, the facilitators focused on simple concepts, such as negative thoughts and their relationship to feelings and actions. Generally, the facilitators focused on the main theme for the session. Tangential topics, such as feelings of guilt associated with child rearing, that were important to the women were incorporated into the sessions. All modifications were consistent with the theoretical principles of CBT, which remained the guiding framework for the intervention.

The intervention helped participants understand factors that contribute to depression, general characteristics of depression, methods for decreasing the impact of depression, and coping strategies to minimize future occurrences of depression. The CBT group intervention may have been effective for some participants because it provided participants an opportunity to share experiences and learn from each other. Discussions of their depression revealed challenges such as being away from family and feeling culturally isolated. The women also expressed guilt, inadequacy, and sadness in their maternal roles, which often led to negative thoughts.

"Being understood" was important to participants. The women believed that their emotions were too intense to be controlled, and the group cohesion and interpersonal validation that occurred among the women were particularly helpful in addressing that belief.

The intervention provided an opportunity for the women to tell their stories, be understood, and learn from each other. On the basis of the report of several group participants, those who were "bursting at the seams" to tell their stories experienced a normalization of symptoms, which was quite helpful.

Also, creating lists of behavioral changes provided a vehicle through which the women were able to solve problems and develop strategies to address depressive triggers. One challenge the women addressed was their isolation and distance from their families. The women decided to contact their families in Mexico more frequently by using e-mail and making phone calls.

The cofacilitators of the CBGT were a white woman and a man, both of whom were bilingual but not bicultural. Gender, race, and ethnicity of the cofacilitators could have played a role in the response to the intervention. We do not believe that gender had a negative effect on the intervention, although race and ethnicity may have. Group facilitators of Mexican decent may have been better able to make group participants feel understood and at ease. More research is needed on the effect of gender, race and ethnicity and coleadership on CBGT and treatment outcomes.

The sixth aim: Implications and dissemination

The final step involved dissemination of the findings as well as plans to expand or evolve this into a larger study to assess the benefit of using this particular CBGT intervention among Mexican women living in emerging immigrant communities. This article will serve as part of our efforts to disseminate the findings.

While in 2 earlier studies,[34,38] the Muñoz and Miranda CBGT intervention was found effective in reducing depression levels in women, including Latinas, in 2 earlier studies, no studies have examined the effectiveness of a CBGT intervention for depressed women of Mexican origin residing in areas of the United States where traditional Latino social, familial, and cultural networks are lacking. The intervention may have helped these depressed Spanish-speaking women from Mexico living in an emerging community in the United States feel understood, which is an important aspect of psychiatric/mental healthcare,[39–43] but we do not know whether it is effective at decreasing depressive symptoms in this population. While the sample was small, this is an important early step toward future studies that may improve the mental healthcare of women from Mexico living in emerging communities in the United States.

Unlike Latinas in established urban communities, Latinas who live in emerging Latino communities in the United States are often geographically, linguistically, and socially isolated, not only from family but also from other Latinas. As a result, these women may not have the support and validation of family or other Latina mothers, mentors, or role models, and they may feel inadequate, conflicted, and guilty about their mothering skills. Since the maternal role is a high priority for Latinas,[44] the conflict, inadequacy, and guilt are potentially significant in depression. This group intervention, however, provided opportunities for participants to express their feelings about their maternal roles and associated challenges. Learning that other women also experienced these feelings seemed to help normalize the feelings, based on oral participant reports. Including education to improve parenting skills, and other issues raised during the group, such as education about anxiety, worry, phobias, anger management, antidepressant medications, and education about myths of mental illness and treatment could strengthen the intervention.

That at least one of the women in this study was an undocumented Mexican immigrant is an important consideration, as reported by a participant during one of the sessions. As Sullivan and Rehm[45] noted, undocumented Mexican immigrants are a unique subgroup within a minority group with little known about their health and mental issues. While better general physical health among first-generation immigrants is believed to also be

true of mental health among undocumented Mexican immigrants,[45] the prevalence and severity of depression among the women in this pilot indicates that further investigation is needed.

Limitations of the study include the small convenience sample and possible reliability and validity issues related to the Spanish version of the CES-D tool. Community collaborators referred participants to the study who were known by them (community collaborators), which could have had an effect on the findings. For example, community collaborators could have referred individuals whom they knew to be motivated and interested in mental health treatment, which could have led to a better than expected retention rate. Another limitation was that data were not collected about the level of acculturation or assimilation of the participants, which may have had a relationship to depression and depressive symptoms. Further research on depression and depressive symptoms in this population, as well as on the reliability and validity of the Spanish version of the CES-D, is warranted.

Studies with Spanish-speaking Latina women from Mexico living in an emerging immigrant community are possible and rewarding, but they are difficult. Barriers to research include transportation problems, childcare issues, undocumented participants' fears, and the intervention location. We recommend locations other than a college campus. College campuses can be difficult to navigate for those unfamiliar with them. Locations such as churches, libraries, and childcare centers, where Latina women are familiar and where they already frequent, are recommended.

IMPLICATIONS FOR NURSING

This work has several implications for nurses working in all areas of healthcare. It speaks to the need for assessment of depression among immigrant Latinas. If the women in this feasibility study can be considered representative, then at least some Latinas are willing to accept professional help for depression and education regarding child rearing. In addition, a willingness by the Latinas to participate in a CBGT intervention was identified. There is a need for providers and therapists who are fluent in the Spanish language to work with Latinas in their native language. This is important to capture accurate understandings of the connotations of words, actions, and body language. Group therapy can be effective in helping Latinas normalize what they are experiencing and feeling. Interdisciplinary collaboration with community resources is beneficial in accessing and supporting women at risk. Culturally sensitive education regarding mental healthcare and child raising practices needs to be developed and delivered to the Latino community, healthcare providers, and general public. There is a general need to increase mental health services in emerging rural immigrant communities.

Nursing research is needed to develop knowledge about mental health needs and care of Latinas in emerging communities. Specifically, research is needed to learn more about the experience of depression among these women, what contributes to depression, and what is most effective in managing it.

Finally, it is imperative to remember that nurses are in a position to continually learn from the patients with whom they interact. The participants in this study taught us that this is particularly true when working with members of an emerging immigrant community.

CONCLUSION

This article reported feasibility issues with the implementation of an intervention study for depression in Latina women from Mexico living in an emerging immigrant community in the United States. Based on the PRECEDE-PROCEED model, the study explored implementation issues such as the intervention and retention; logistical issues such as transportation and childcare, and

possible measurement issues such as reliability and validity of the CES-D, Spanish version. Future studies should evaluate the CES-D, Spanish version, and test the modified CBGT intervention in larger samples and through randomized controlled studies.

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