A Mixed-Methods Evaluation of the Feasibility of a Group Treatment for Depression Among Immigrant High School Students

By

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ABSTRACT

Despite the well-known efficacy of evidence-based treatments in treating depression in youth (Weersing & Weisz, 2002), few studies have examined their effectiveness among immigrant youth, nor the process of implementing these treatments in schools with diverse populations (Huey & Polo, 2008; Ngo et al., 2008). Accordingly, there has been a call for research examining the effectiveness of evidence-based treatments with culturally diverse youth (David-Ferdon & Kaslow, 2008; Kataoka, Novins, & Santiago, 2010), particularly immigrant youth (Peña et al., 2008; Potochnick & Perreira, 2010). This study represents an important first step in that process, the examination of the feasibility of a group treatment for depression among immigrant high school students. An evidence-based group treatment was offered to immigrant students who displayed depressive symptoms in a diverse, urban high school, and data was collected on the implementation process. Quantitative data revealed that therapists were able to implement the majority of treatment components with satisfactory fidelity. However, low student attendance and retention rates suggested that the group treatment was not feasible as implemented. Qualitative analyses of interviews and treatment notes provided a detailed description of the barriers and facilitators of the group treatment and also suggested avenues for improving the feasibility of future mental health interventions in diverse school settings. Results will inform future efforts to transport evidence-based treatments into diverse, urban schools, thus improving outcomes for immigrant youth.

CHAPTER I

INTRODUCTION

This study explores the implementation process of an evidence-based treatment for depression among immigrant adolescents in an urban high school. This chapter consists of a brief overview of the prevalence and negative effects of youth depression as well as the unique vulnerability of immigrant youth to developing depressive symptoms. These concepts are also discussed in further detail in the subsequent chapter. At the end of the subsequent chapter, the statement of purpose, the research questions, and the hypotheses associated with these research questions are presented for this study.

Depression is a widespread and serious mental health problem among adolescents in the United States (US). In the general US population, approximately 11.4% of adolescents ages 12 to 17 experience a major depressive episode each year, and approximately 20% of youth experience at least one major depressive episode by the age of 18 (Lewinsohn, Hops, Roberts, Seeley, & Andrews, 1993). The negative effects of depression can be far-reaching and life-threatening. In addition to decreases in academic performance and social functioning, adolescents with depression face increased risk of substance abuse problems and recurrent episodes of mood disorders (Stark, 1990). Further, depression significantly increases the risk for self-harming behaviors, including suicide attempt and completion (Hawton, Saunders, & O'Connor, 2012).

Immigrant and immigrant-origin youth are uniquely vulnerable to developing depressive symptoms (Pumariega, Rothe, & Rogers, 2009); and they constitute the fastest growing sector of US population (Passel, 2011). Moreover, immigrant communities often face additional challenges around mental health problems, including lower access to

services and evidence-based treatments (e.g., Abe-Kim et al., 2007). Offering mental health services in schools has been shown to decrease barriers to care and reduce mental health disparities (Lyon, Ludwig, Vander Stoep, Gudmundsen, & McCauley, 2013). However, questions remain about the applicability of existing evidence-based psychosocial treatments to ethnic minority and immigrant youth (Kataoka et al., 2010), as well as the processes that facilitate transportation of treatments from research settings into practice (Proctor et al., 2009). As the US population becomes increasingly diverse, establishing evidence-based treatments that effectively reduce depressive symptoms in immigrant youth and facilitating the use and acceptability of those treatments are pressing national needs.

CHAPTER II

LITERATURE REVIEW

Epidemiology and Risk Factors

As a nation of immigrants, the US has a history of receiving newcomers from a wide variety of cultural backgrounds onto its shores. While it has negotiated larger percentages of immigrants in the past, the US currently is home to its highest overall number of immigrants, approximately 39.9 million people (American Psychological Association, 2012; US Census Bureau, 2012). This changing demographic and cultural landscape is the result of several major factors, including the progressive aging of the European-origin population and lower average ages and higher birthrates among non-European minority groups (Passel, 2011; Pumariega et al., 2009). Additionally, recent years have seen an influx of immigrants from developing countries, with the largest number of foreign-born youth arriving from Latin America, Asia, and the Caribbean (Passel, 2011; Pumariega et al., 2009). As a result, immigrant and immigrant-origin youth are the fastest growing sector of the US population. More than 20% of youth under age 18 are foreign-born (first-generation) or have at least one foreign-born parent (second-generation), and approximately 25% of adolescents are part of an immigrant family (Mather, 2009)[1]. The population of immigrant youth is projected to increase further in the coming decades, with Latino and Asian populations expected to comprise 25% and 8% of the US population by 2050, respectively (Passel, 2011). Projections indicate that European-origin Americans will no longer constitute a numeric majority by 2050; and this will happen before 2030 among people younger than 18 (Passel, 2011).

[1] This paper will use the term *immigrant* to refer collectively to first- and second-generation immigrants.

The large and increasing presence of immigrant youth is highly relevant to youth mental health services. Research indicates a growing prevalence of mental health problems among immigrant youth (Merikangas et al., 2011; Siren, Ryce, Gupta, & Rogers-Siren, 2013). In regard to depressive symptoms and disorders, Latino youth have higher rates of depressive symptoms (22%) than White (18%), Asian American (17%), and African American (15%) youth (Saluja et al., 2004). This concern is exemplified by the comparatively higher rates of suicidality and suicide attempts among Latino youth (11.3%), as compared with European-origin youth (6.8%), as highlighted by the most recent Youth Risk Behavior Survey (Kaan et al., 2016). Further, Asian immigrant youth have demonstrated similar patterns with regard to increases in depression, with some studies showing higher rates of internalizing symptoms (e.g., depression, anxiety) than those found in majority culture peers (Hovey, Kim, & Seligman, 2006; Lo, 2010; Lorenzo, Frost, & Reinherz, 2000).

Additionally, gender differences affect depression rates, and generational differences may play a role. Consistent with the larger population of US adolescents (Kaan et al., 2016), immigrant females experience higher rates of depression than males (Céspedes & Huey, 2008; Dawson, Perez, & Suárez-Orozco, 2012; Tummala-Narra & Claudius, 2013). Mixed findings have been reported on generational differences: some studies have found evidence for an "immigrant paradox," in which second-generation adolescents experience more internalizing problems than their first-generation peers, despite the migration stressors and language barriers that affect first-generation immigrants (Cervantez, Padilla, Napper, & Goldbach, 2013; Harker, 2001). Other studies either have not found a mental health disparity across generations (Hao & Woo, 2012;

Peña et al., 2008) or have found that first-generation adolescents report more internalizing problems than their second-generation peers (Katsiaficas, Suárez -Orozco, Siren, & Gupta, 2013; Polo & Lopez, 2009; Potochnick, Perreira, & Fuligni, 2012).

Several factors contribute to the higher risk of depression among immigrant youth, including discrimination, language and cultural adjustment challenges, and low socioeconomic status (Cho & Haslam, 2010; Davis et al., 2016; Kramer, Kwong, Lee, & Chung, 2002). Many studies have documented the adverse effects of both subtle and overt forms of discrimination on the psychological well-being of various immigrant communities (e.g., Jasinskaja-Lahti, Liebkind, Jaakkola, & Reuter, 2006; Liebkind & Jasinskaja-Lahti, 2000; Yip, Gee, & Takeuchi, 2008). Experiences of discrimination may be especially detrimental for adolescents, as they tend to be more sensitive to the ways in which they are perceived socially (Blakemore, 2008). Immigrant Latino and Asian American adolescents who experience higher levels of stereotyping and discrimination by peers and adults report higher levels of depressive symptoms than those who experience lower levels (Greene, Way, & Pahl, 2006; Tummala-Narra & Claudius, 2013). Notably, both positive and negative stereotyping can contribute to adverse developmental outcomes (Yoo & Castro, 2011). For example, many Asian American youth feel pressure to conform the "model minority" stereotype, resulting in increased stress and pressure to perform academically at a level that feels unattainable (Lee et al., 2009; Yoo & Castro, 2011).

In addition to exposure to discrimination, immigrant youth face increased acculturative stress, defined as the reaction to intercultural contact or the cultural adaptation process (Berry, 2006). Acculturative stressors can include the process of

learning a new language, balancing different cultural values, and navigating different social norms and behavioral expectations (Caplan, 2007; Dawson & Panchanadeswaran, 2010). Among immigrant adolescents, acculturative stress has been associated with higher levels of depression and suicidal ideation (Hovey & King, 1996) as well as more withdrawn, somatic, and anxious/depressive symptoms (Hwang & Ting, 2008; Sirin et al., 2013). Additionally, many immigrant youth live in urban and/or impoverished communities with increased exposure to victimization, witnessing acts of violence, abuse, neglect, and caregiver depression (Sheidow, Henry, Tolan, & Strachan, 2014; Suárez-Orozco & Suárez-Orozco, 2009). These circumstances subject immigrant youth to stressors and traumas associated with increased rates of depressive symptoms and suicidality in all populations, but which are exacerbated by the stressors associated with acculturation and discrimination (Jaycox et al., 2002; Pumariega et al., 2009).

Disparities in Mental Health Services Access and Use

Despite the growing prevalence of mental health concerns and depression risk, immigrant youth underutilize mental health services in comparison to their European-origin peers (Cummings & Druss, 2011; Kataoka, Zhang, & Wells, 2002). In the general US population, only 38% of depressed adolescents access any treatment, including prescription medication, outpatient mental health services, and/or counseling in a school setting (Cummings & Druss, 2011). Among racial/ethnic minority youth, this percentage is even lower. Only 31% of Latino and 19% of Asian American adolescents with major depression receive any treatment (Cummings & Druss, 2011). These differences persist even after controlling for family income and insurance status (Cummings & Druss, 2011), and they reflect broader disparities in access to mental health care among

racial/ethnic minority and immigrant groups in the US. Latino children, for example, have high rates of unmet mental health need relative to other children, receiving an average of half as many counseling sessions and significantly fewer specialty mental health services than their majority-culture peers – and at a later age (Hough et al., 2002; Kataoka et al., 2002). Asian Americans, especially immigrants, demonstrate lower rates of any type of mental health service use than the general population (Abe-Kim et al., 2007). Only 7.4% of foreign-born and 12.7% of US-born Asian Americans seek any type of mental health support, compared with 17.9% of the general population (Abe-Kim et al., 2007).

A number of logistical and cultural barriers limit access to mental health services for immigrant youth. Immigrant families often lack public or private insurance and reside in neighborhoods where mental health and general medical care is rarely available (Pumariega, Rothe, & Pumariega, 2005; Shobe, Coffman, & Dmochowski, 2009). These issues are particularly acute among young children and Latino youth (Kataoka et al., 2002). Compounding this problem is the limited availability of linguistically- and culturally-appropriate care: language barriers often prevent immigrants from seeking mental health care (DuBard & Gizlice, 2008; Kirmayer et al., 2011), and cultural mismatches between client and therapist often result in early termination of care (Leong & Lao, 2001). Transportation, financial, and scheduling concerns also impede access to care (Owens et al., 2002). Additionally, cultural beliefs, including negative perceptions about mental health problems and services, further limit the extent to which mental health care is seen as a realistic and acceptable option for immigrant youth. Particularly among Asian immigrant and Asian American youth, perceived public stigma and shame

associated with mental health treatment prevents distressed youth from seeing help (Choi & Miller, 2014; Eisenberg, Downs, Golberstein, & Zivin, 2009).

Whereas immigrant youth are less likely to seek and receive mental health services than their majority-culture peers, they are also less likely to be referred to those services. Internalizing problems among immigrant adolescents are often unrecognized by their parents, teachers, and peers (Patel & Kull, 2011). Further, primary care physicians under-diagnose depressive symptoms in Latino and Asian patients, particularly those with low acculturation levels (Chung et al., 2003). For immigrant youth who access outpatient mental health and inpatient psychiatric care, problems around misdiagnosis remain. Various studies have found an over-diagnosis of conduct disorder and under-diagnosis of depressive disorders among Latino and Asian youth (Delbello, Lopez-Larson, Soutullo, & Strakowski, 2001; Kilgus, Pumariega, & Cuffe, 1995; Nguyen, Arganza, Huang, & Liao, 2007). Misdiagnosis largely originates from clinicians' difficulties accurately assessing and addressing cultural differences, including differences in symptom presentation across cultures (Whaley & Geller, 2007). Adolescents from diverse populations often demonstrate different depressive symptomatology (Anderson & Mayes, 2010). Somatic symptoms, for example, are more frequently associated with depression in minority youth (Choi & Park, 2006; Kirmayer, 2001). The degree of emotional reactivity also can vary during depression, with Asian-origin Americans showing heightened reactivity, whereas European-origin Americans show less (Chentsova-Dutton et al., 2007). Diagnosing depression in immigrant youth can be challenging to clinicians unfamiliar with these issues. The frequent presence of comorbid conditions in immigrant youth also contributes to these challenges. For example,

experiences of immigration, discrimination, acculturation, and community violence are associated not only with depression but also with substance use, anxiety, and post-traumatic stress (Almeida, Johnson, Matsumoto, & Godette, 2012; Jaycox et al., 2002; Potochnick & Perreira, 2010). All of these factors result in increased mental health disparities and significant underuse of mental health services among immigrant youth.

School-Based Mental Health

School-based mental health has emerged as an innovative way to reduce unmet mental health needs among youth and reduce racial disparities in care (Lyon et al., 2013). Situating mental health care in schools has been found to reduce or eliminate logistical barriers to accessing care (e.g., transportation, financial, insurance, and scheduling concerns) and reduce stigma associated with help-seeking (Slade, 2002; Weist, 1999). Indeed, school-based mental health is significantly more likely to be utilized by youth than outpatient specialty mental health care (Jaycox et al., 2010; Kataoka et al., 2002). Of those youth able to access any form of mental health care, 70-80% receive services in schools (Hoagwood, Burns, Kiser, Ringeisen, & Schoenwald, 2001; Rones & Hoagwood, 2000).

Because providing mental health treatment in schools decreases both logistical barriers and stigma, schools have been posited as an ideal environment for engaging and retaining urban youth who may not otherwise receive treatment (Ginsburg, Becker, Kingery, & Nichols, 2008). Providing services in schools also has extended the reach of mental health care to racial and ethnic minority youth and families who otherwise are unlikely to receive treatment (Stephan, Weist, Kataoka, Adelsheim, & Mills, 2007). For example, Juszczak, Melinkovich, and Kaplan (2003) found that Latino and African

American youth were 20 times more likely to seek and receive school-based mental health care than outpatient community care over a five-year period. Additionally, in a nationally-representative sample, Cummings, Ponce, and Mays (2010) demonstrated that some of the disparities that disfavor Latino and Asian American adolescents in specialty mental health settings were not, in fact, present in school-based mental health. Specifically, the likelihood of receiving critically-needed treatment for depression, suicidal ideation, and delinquency in a school-based setting was no different for ethnic minority and non-Hispanic White youth (Cummings et al., 2010). Thus, school-based mental health is a promising care delivery system that can reduce racial disparities in access to and utilization of mental health services.

Yet, despite the potential of school-based mental health to decrease barriers and increase access to care, inequalities still persist. Even within school-based mental health, ethnic minority students are less likely than non-Hispanic White students to receive care, less likely to be referred to specialty mental health services, and less likely to begin treatment at an early age (Wood et al., 2005). Discrepancies in service utilization persist not only between ethnic minority and non-Hispanic White students, but also between different ethnic minority groups (Garland et al., 2005; Gudiño, Lau, Yeh, McCabe, & Hough, 2009). Asian Americans, in particular, are more likely to have unrecognized and unmet mental health needs in schools, even when compared to other immigrant and ethnic minority groups (Bear, Finer, Guo, & Lau, 2014). For example, Guo, Kataoka, Bear, and Lau (2014) examined rates of mental health referrals for Latino and Asian American students in a large urban school district with a high percentage of immigrant and low-income families. They found no differences in rates of overall mental health

need between Latino and Asian American students; yet, Latino students were 4.49 times more likely than Asian American students to be referred to mental health care by teachers and other school personnel. Moreover, among students with mental health need, as demonstrated by elevated symptoms and functional impairment, Latino students were 63.1 times more likely than Asian Americans to be referred to care (Guo et al., 2014). These discrepancies are partially explained by Asian American students' relative academic success (Tran & Birman, 2010) and lower externalizing problems (e.g., conduct problems, aggression; Chang, Morrissey, & Koplewicz, 1995) that can be disruptive to the classroom (Guo et al., 2014); and they highlight the need to screen for mental health problems – particularly internalizing problems that are less observable in the classroom – in more comprehensive ways.

Another pressing need in school-based mental health is the expanded use of high-quality evidence-based treatments. The US Public Health Service Report from the Surgeon General's Conference on Children's Mental Health (Satcher, 2001) noted that, even when mental health services are provided in schools, they are often in short supply and of poor quality. Many school-based providers have limited training in efficacious treatments for youth depression and are therefore poorly equipped to treat students in empirically-supported ways (Reinke, Herman, Stormont, Brooks, & Darney, 2010). For example, studies have found that youth who receive community-based (albeit not school-based) treatments for depression tend to show limited improvement – similar to youth who receive no treatment in clinical trials (Weersing & Weisz, 2002). In order to address the unmet mental health needs of immigrant youth, it is essential that school-based

mental heath providers attend not only to which populations are accessing services but also to which treatments are being implemented and how.

Evidence-Based Treatments for Youth Depression

Over the past several decades, a range of psychological treatments for youth depression have been developed, with varying degrees of empirical support (Chorpita et al., 2011). The psychosocial approaches with the strongest evidence base for the treatment of youth depression are cognitive-behavioral therapy (CBT) and interpersonal psychotherapy (IPT; David-Ferdon & Kaslow, 2008). For the treatment of adolescent depression, group CBT and individual IPT have been identified as "well-established" treatments (David-Ferdon & Kaslow, 2008). CBT, in particular, has been widely researched and has demonstrated efficacy across a wide range of client characteristics, therapist characteristics, formats, and settings (Chorpita et al., 2011; Spirito, Esposito-Smythers, Wolff, & Uhl, 2011). In comparison to youth who receive usual care for depression (e.g., eclectic and/or psychodynamic treatment) in community mental health centers, youth who receive CBT demonstrate greater and more immediate symptom reduction and better long-term retention of gains (Weersing & Weisz, 2002). Additionally, large-scale clinical trials have supported the use of psychotropic medication in combination with CBT for reducing depressive symptoms and improving overall functioning in adolescents (Brent et al., 2008; Goodyer et al., 2007; March et al., 2004; Melvin et al., 2006). The addition of a selective serotonin uptake inhibitor (SSRI), for example, to CBT produces improvements at a significantly faster rate than CBT alone. However, CBT alone is effective; and it is an important component of any treatment that includes an SSRI as it helps to prevent the suicidal ideation and behavior that is often

associated with taking an SSRI (TADS Team, 2007).

Several specific CBT protocols for the treatment of youth depression have been developed and supported in clinical trials (David-Ferdon & Kaslow, 2008). These include Self-Control Therapy (Stark, Reynolds, & Kaslow, 1987), the Penn Prevention Program (Jaycox, Reivich, Gillham, & Seligman, 1994), and Coping with Depression-Adolescent (Clarke, Lewinsohn, & Hops, 2000; Clarke, Rohde, Lewinsohn, Hops, & Seely, 1999). These treatments have consistently yielded reductions in depressive symptoms relative to controls; and they were therefore identified as "probably efficacious" – the highest rating given to specific interventions – in a comprehensive review of psychosocial treatments for childhood and adolescent depression (David-Ferdon & Kaslow, 2008). Each consists of manualized or otherwise prescribed intervention procedures that incorporate a combination of CBT components such as mood monitoring, affect regulation, pleasant activity scheduling, cognitive restructuring, social skills, communication, and conflict resolution (David-Ferdon & Kaslow, 2008). Other specific interventions for youth depression also have demonstrated efficacy (e.g., ACTION Treatment Program [Stark, Streusand, Arora, & Patel, 2012]; Primary and Secondary Control Enhancement Therapy [PASCET; Weisz, Southam-Gerow, Gordis, & Connor-Smith, 2003]).

The continued growth of well-designed, randomized controlled trials examining the efficacy of psychosocial treatments for youth depression has bolstered the evidence-based status of specific CBT interventions, as well as CBT as a general modality of treatment. However, relative to other problem areas for youth that are addressed by psychosocial treatments, the number of studies examining interventions for depressed youth is small (David-Ferdon & Kaslow, 2008). Accordingly, there are many directions

for future research to consider and explore. Notably, since much of the efficacy data for depression treatments comes from studies conducted predominantly with European-origin youth (e.g., Ackerson, Scogin, McKendree-Smith, & Lyman, 1998; Clarke et al., 2001; March et al., 2004; Rohde, Clarke, Mace, Jorgensen, & Seeley, 2004), questions remain about the applicability of these evidence-based treatments to culturally diverse and immigrant youth.

Effectiveness of Evidence-Based Treatments with Diverse Youth

Given the underrepresentation of culturally diverse and immigrant youth in clinical trials and the alarming mental health disparities, researchers are increasingly considering the generalizability of treatments to ethnic minority youth and the interface of cultural factors with treatment effectiveness and implementation (e.g., Bernal, Jiménez-Chafey, & Domenech Rodríguez, 2009; Kataoka et al., 2010; Pumariega, Rogers, & Rothe, 2005). When considering whether evidence-based treatments generalize to ethnic minority youth, researchers have tended to espouse one of two competing viewpoints: the *ethnic invariance* perspective or the *ethnic disparity* perspective (De Anda, 1997; Huey & Polo, 2010). The ethnic invariance perspective purports that the efficacy of evidence-based treatments will be similar for all ethnic groups, since the core components of therapeutic change are considered to be universal. By contrast, the ethnic disparity perspective holds that treatments will be less effective for ethnic minority groups, given that many treatments were developed by and for European-origin populations and generally incorporate Western principles (e.g., individualistic versus collectivist perspectives on healthy functioning; De Anda, 1997; Huey & Polo, 2010).

In the broader literature on evidence-based treatments for a variety of psychosocial problems (e.g., anxiety, attention-deficit/hyperactivity disorder, conduct problems), most studies show positive effects when examining the efficacy of evidence-based interventions with individuals from different cultural groups (Griner & Smith, 2006; Huey & Polo, 2008; Miranda et al., 2005). However, the evidence for ethnic disparities in treatment outcomes for youth is equivocal. In a meta-analysis of evidence-based treatments for ethnic minority youth, Huey and Polo (2008) found that most studies of various disorders showed no ethnicity effects. This suggests that treatments were equally potent regardless of youth ethnic background; however, null effects may have resulted from low power to detect moderator effects and/or failure to account for nonsystematic cultural modification (Huey & Polo, 2008; Huey & Polo, 2010). Additionally, whereas Latino and African American youth were well-represented in many efficacy trials, other ethnic minority groups (e.g., Asian Americans, Native Americans, Pacific Islanders) were mostly absent from the literature.

With regard to the treatment of internalizing problems in youth, cognitive behavioral approaches have demonstrated the strongest record of success (Griner & Smith, 2006; Huey & Polo, 2008; Miranda et al., 2005). Several studies support the use of group CBT for Latino and African American youth with anxiety disorders (Ginsburg & Drake, 2002; Silverman et al., 1999). For example, African American adolescents who participated in group CBT that was adapted for the school setting (e.g., reduced length of treatment, exclusion of parent component) demonstrated decreased anxiety symptoms and significant improvement in comparison to an attention-support control (Ginsburg & Drake, 2002). In a separate study, Latino children and adolescents who had a DSM-III

diagnosis of social phobia, overanxious disorder, or generalized anxiety disorder demonstrated significant improvements in anxiety symptoms relative to a waitlist control; and treatment benefits did not differ by ethnicity (Latino vs. White; Silverman et al., 1999). CBT interventions have also demonstrated efficacy in the treatment of trauma-related disorders with ethnic minority youth. In a multisite study of sexually abused children and young adolescents with posttraumatic stress disorder (PTSD), Cohen, Deblinger, Mannarino, and Steer (2004) found that Trauma-Focused Cognitive-Behavioral Therapy (TF-CBT; Deblinger & Heflin, 1996) led to greater PTSD symptom reduction than child-centered therapy. This study included primarily African American and White youth, and treatment benefits did not differ by ethnicity (Cohen et al., 2004). Another CBT, Cognitive-Behavioral Intervention for Trauma in Schools (CBITS; Stein et al., 2003), was found to be efficacious for Latino youth – including Latino immigrant children – with PTSD symptoms. Notably, some studies evaluating the efficacy of CBITS with Latino youth also documented decreases in trauma-related depressive symptoms (Kataoka et al., 2003; Ngo et al., 2008).

Research on evidence-based treatments for depression with ethnic minority youth is less robust; in fact, it is limited to a small number of clinical trials conducted primarily with Latino adolescents. In a randomized trial conducted in Puerto Rico with depressed adolescents, Rosselló and Bernal (1999) found that individual CBT and IPT significantly reduced depressive symptoms compared to a waitlist control. In a subsequent trial, Rosselló, Bernal, and Rivera-Medina (2008) evaluated the relative efficacy of CBT and IPT delivered in group and individual formats. Results suggested that both treatments – in both formats – were efficacious for depressed Puerto Rican adolescents, though CBT