Toward an Adaptation of Interpersonal Psychotherapy for Hispanic Patients With DSM-IV Major Depressive Disorder

John C. Markowitz, M.D.; Sapana R. Patel, Ph.D.; Ivan C. Balan, Ph.D.; Michelle A. Bell, Psy.D.; Carlos Blanco, M.D., Ph.D.; Maria Yellow Horse Brave Heart, Ph.D.; Stephanie Buttacavoli Sosa, Ph.D.; and Roberto Lewis-Fernández, M.D.

Background: Spanish-speaking individuals comprise a growing percentage of the United States population. They have greater difficulty than most in accessing and remaining in psychiatric treatments, including psychotherapy, their stated preference. The literature on cultural competence in treating Hispanic patients provides few details of psychotherapeutic adaptations.

Objective: This article, based on interpersonal psychotherapy (IPT) supervision for a low-socioeconomic sample of monolingual Spanish-speaking New York City patients, describes culturally specific psychotherapy.

Method: In conducting IPT for Spanish-speaking patients with DSM-IV major depressive disorder, we reviewed cases in weekly supervision over 3 years (January 2005 to January 2008) to explore treatment themes and evaluate the congruence of IPT in addressing them. Important themes are illustrated by case example.

Results: Key themes include (1) the centrality of family, (2) conflicts due to migration and acculturation, (3) gender roles, (4) need to avoid humiliating or irrevocable social confrontation, and (5) equanimity in facing an unpredictable environment.

Conclusions: IPT appears a compatible intervention, focusing on and adaptable to these important issues for Hispanic patients.

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Corresponding author and reprints: John C. Markowitz, M.D., New York State Psychiatric Institute, 1051 Riverside Dr., Unit #129, New York, NY 10032 (e-mail: jcm42@columbia.edu).

Hispanic individuals, whose 13% of the population constitutes the largest U.S. minority group,[1] underutilize mental health services relative to non-Hispanic whites and to their own mental health needs.[2–7] They are less likely both to enter mental health care and to stay once care begins. Research on the clinical aspects of psychiatric treatment for Hispanics and other minorities is limited, particularly for empirically supported treatments. The minimal involvement of Hispanics in psychotherapy studies[8,9] has raised concern about whether empirically supported treatments such as interpersonal psychotherapy (IPT) and cognitive behavioral therapy, tested mainly in samples of majority white women, apply to cultural minorities.[10–12]

Culture has 2 components: practices and worldviews. Cultural practices concern acts (e.g., circumcision), whereas cultural worldviews refer to the belief systems a group shares (e.g., circumcision is a religious sacrifice or a hygienic operation). A human construct, culture pervades life, including political, legal, social, educational, mercantile, and medical systems and institutions. Clinicians need to adapt treatments to meet the cultural needs

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of Spanish-speaking patients of varied national origins and retain these patients in treatment.[13] Several extant frameworks for adapting psychotherapy to culturally diverse populations[10–12,14–17] begin by transforming knowledge about a patient's culture into "concrete operations and strategies," a challenging yet crucial step to providing culturally sensitive treatment.[18]

This article discusses a preliminary adaptation of IPT for Hispanics with DSM-IV major depressive disorder (MDD), for whom its high prevalence is a major public health problem. Our findings emerged from cultural discussions arising in IPT supervision for depressed, low-income, Spanish-monolingual Hispanics in New York City during 2 studies led by the senior author (R.L.-F.). Highlighting themes and considerations clinicians made in treating these patients may contribute to the cultural treatment literature.

Interpersonal Psychotherapy

Time-limited, diagnosis-focused IPT has demonstrated efficacy for MDD.[19,20] Interpersonal psychotherapy focuses on connections between mood and life events: upsetting circumstances may trigger depressive episodes in vulnerable individuals; depressive symptoms impair social functioning, triggering disheartening events that worsen mood. Interpersonal psychotherapy defines depression as a treatable medical illness that is not the patient's fault, a stance that mitigates symptomatic guilt and hopelessness. Hopelessness, anxiety, and guilt are labeled as symptoms likely to improve with treatment.[19,20]

IPT therapists diagnose patients with MDD and link the illness episode to a focal interpersonal problem area elicited from the history: *grief* (complicated bereavement following a death), *role dispute* (struggle with a significant other), *role transition* (any life change: in job, relationship, health; immigration), or *interpersonal deficits* (social isolation; no life events). The goal is to solve this interpersonal crisis over 12 to 16 weekly sessions, an accomplishment that simultaneously improves the patient's life situation, builds social skills and social supports, and relieves depressive symptoms. Randomized controlled trials have repeatedly validated this approach.[19]

Sessions link life events and mood changes occurring during the week between sessions. The IPT therapist elicits the patient's emotional responses in interpersonal encounters, validates those feelings when possible, and encourages the patient to voice them appropriately. This often involves direct verbal confrontation with significant others. Exploring and role-playing options for improving situations are key treatment components.[19,20]

Research on IPT in Hispanic Patient Samples

Hispanics often envision goals of mental health treatment beyond simple symptom remission: to regain equanimity, emotional control, and the abilities to function, contribute to society, and maintain social relationships, especially family unity.[12,21–23] These goals echo the IPT emphases on mobilizing social supports and improving interpersonal relations and functioning. Interpersonal conflicts in marriage and family are common issues in psychotherapy for Hispanics.[12,14,15,24,25] Thus IPT shares the emphasis on interpersonal relatedness found in Hispanic cultures. This matters, as cultural syntonicity and patient preferences influence treatment entry and adherence.[26–28] Yet research on IPT's effectiveness for Hispanics is limited,[29–32] and no published studies clearly define adaptations based on patients' ethnicity.

Adapting IPT for Hispanic Patients

Adaptation of psychotherapy can have more than one meaning. A technical adaptation changes the form or ingredients of a psychotherapy to fit a particular treatment population. Frank's[33] hybridization of interpersonal psychotherapy and behavioral social rhythms therapy for bipolar disorder is one example; adjusting IPT to Ugandan villages where trained therapists were unavailable is another.[34] We retained the general IPT approach, emphasizing some interventions and subtly muting others. For example, in working with this treatment group, we learned to de-emphasize (while not entirely abandoning) the medical model and to help patients find less direct ways of confronting family problems than in Anglo populations.

Psychotherapy can also be culturally adapted, a process several authors have mapped out for evidence-based psychotherapies.[16,17,35,36] Although we did not formally work from these published frameworks, we took a qualitative approach to our Hispanic, largely immigrant patients, fine-tuning an evidence-based psychotherapy (IPT) to a subcultural sample to address the particular stressors, values, and coping strategies of the group. This involved information gathering from therapists experienced in both IPT and work with Hispanic patients, and from the patients themselves; a preliminary adaptation design; and iterative refinement of our approach based on case studies.[36(p314)] It did not involve other common methods of cultural approaches, such as meeting with community focus groups. The results yielded an IPT approach, still recognizably IPT but tellingly adjusted, that appeared helpful to patients and can be tested in more formal, quantitative outcome trials. It is thus less a full-blown adaptation than an adjustment of IPT, the first step toward such an adaptation.

METHOD

Clinical Examples

In conducting IPT for monolingual Spanish-speaking patients of mixed regional origins and low socioeconomic status in upper Manhattan, we reviewed cases in weekly supervision over 3 years (January 2005 to February 2008)

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to explore treatment themes and evaluate the congruence of IPT in addressing them. Therapists were 1 bilingual psychiatrist and 4 bilingual psychologists, 2 of them male and 3 female, with 8 to 21 years (mean = 11.4, SD = 5.7 years) of clinical experience working with this clinical population. We illustrate with case vignettes issues that consistently arose.

RESULTS

The Centrality of Family

From an IPT perspective, family can provide social supports that protect against psychopathology[19] and simultaneously trigger disputes with significant others that may precipitate depressive episodes. Family ties may entail unwanted financial pressures, responsibilities, disappointments, and shame over the failings of relatives. In the cases we treated, family issues were ubiquitous. Hence no IPT cases focused on *interpersonal deficits*—i.e., absence of relationships—the most problematic IPT focus.[19,37]

The term *familismo* describes the important role family plays in developing and cultivating individual and group well-being in Latin American culture.[38] Family was paramount for our patients, whose sense of self lay within the larger familial unit. This was particularly true for many patients who migrated to the United States. Often, migration increased reliance on family for lack of other supports. Yet families also raise difficulties, particularly when migrant parents speak little English and children are Anglophone American citizens who interact in school with diverse peer groups. Acculturation gaps may arise, with cultural dissonance between first-generation Hispanics and their offspring over worldviews, expectations, practices, and language. Parents may be at their children's mercy for communication in English, altering the familial balance of power.

> Ms. A, a 54-year-old single Dominican woman, presented with MDD. She lived with her 28-year-old son, who had poorly controlled bipolar disorder and substance abuse. He, responding to auditory hallucinations, aggressively threatened but had never physically assaulted her. Although frustrated by his poor outpatient oversight, she felt ambivalent about having him placed in a residential treatment program. The therapist formulated a role dispute.
>
> Ms. A feared but felt responsible for her son. Caring for him was overwhelming, yet she feared his fate away from home. A friend's son with mental retardation had been placed in independent housing and was killed during a robbery. Ms. A's own mother reiterated this story, insisting that "nobody will take care of him like his mother." Ms. A felt that "as his mother" she could not evict him.
>
> Treatment focused on eliciting her feelings about her son: sadness, hopelessness about his condition, and guilt that her bad mothering might have contributed to his state. Her other son was in prison. As the son at home could not discuss their relationship, treatment explored her other coping options (e.g., having her brother move in), identifying ways to decrease conflict, and accentuating positive interactions with her son. This process built a strong treatment alliance.
>
> Ms. A began to recognize how familial tensions affected her mood. She improved, gaining energy and hope. Following her lead, the therapist reframed her role as a mother caring for her son lest he decompensate and endanger himself or others. When his chronically violent, psychotic symptoms worsened and he struck her, she contacted Emergency Medical Services, precipitating hospitalization for eventual residential placement. Although still concerned about her son living outside the home, Ms. A has asserted herself with hospital personnel who tried to discharge him to her apartment.

This case highlights the maternal role in traditional Hispanic families, subjugating maternal needs to those of children. Keeping her son home outweighed Ms. A's own health and safety. Interpersonal psychotherapy adaptations included exploring ways to resolve the role dispute without direct discussions, and eventually using the cultural norm of caring for children to allow Ms. A to institutionalize her son for his self-protection. Nonetheless, her difficulty in setting limits with a demanding family, in which she as oldest sibling occupied a mothering role, limited the effects of IPT.

> Ms. B, a 58-year-old Dominican woman, presented with complicated bereavement 9 years after a serial rapist murdered her adolescent daughter. She struggled privately with anger, sadness, and guilt for "allowing my daughter to be murdered." A single mother of 4, Ms. B experienced losing her only daughter as an assault on her maternal role. She felt overwhelmed by her daughter's murder, paralyzed in her ability to mourn. She feared losing control of herself; as sole caretaker of her granddaughter (her daughter's only child), she refused to risk this.
>
> Customarily, she explained, families erect domestic shrines to commemorate lost children and conduct a home memorial ceremony on each funerary anniversary, but Ms. B had been unable to mourn in this manner. Ms. B had felt like an outsider at the killer's trial. Having seen the trial as an opportunity to redeem herself as a mother by protecting others from the perpetrator, she felt she had not been taken seriously because of her language barrier and foreign origin. She came to treatment saying she wanted to mourn at her own pace, "*a mi manera*." Acknowledging the cultural importance of the maternal role and incorporating this into the IPT conceptualization, the therapist defined a role dispute over her identity and duty as a mother in her community. Having ventilated her feelings in therapy and role-played conversations she had previously avoided with her granddaughter about her mother's death, Ms. B decided it was time to mourn "*a mi manera*." On the tenth anniversary of the

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murder, Ms. B and her granddaughter laid flowers before her portrait and cooked her daughter's favorite foods to acknowledge her continued spiritual existence. Afterwards, Ms. B felt peaceful and calm within her soul (*sentir paz y tranquilidad en mi alma*). Her guilt resolved and her confidence grew. At termination, euthymic, she was working with Legal Aid to avenge her daughter.

This case required little adaptation of IPT for bereavement, simply exploring and giving the patient permission to address her feelings in a safe, contained space and a meaningful cultural context.

Conflicts Due to Migration and Acculturation

Each generation in immigrant Hispanic families differs in values, acculturation, and mental health issues.[39] Old and new country values may conflict. Geographic distance from the family of origin may cause strains and worsen social isolation. These tensions provide role disputes, which are potential foci for IPT.

Migration is a role transition separating individuals from their countries and cultures. They leave familiar supports and structures for an often alien world. Migrants may bear the financial burden of supporting families left behind. Immigrants may also need to return home periodically to re-engage their relatives. We find patients often feel better after these visits and become dysphoric if such return visits are blocked.

Geography can complicate mourning a death "*en mi país*" (in my country), which can be treated using the IPT focus of complicated bereavement. Migration impeded the return of Ms. C, a 32-year-old single woman, for her mother's funeral. Her IPT therapist sympathized and encouraged the mourning trip home. Having reached her mother's grave in the Dominican Republic, Ms. C reported less guilt, and her depression improved. The planned interruption of therapy created a space for processing her bereavement. Unplanned trips to the native country, by contrast, may interrupt psychotherapy.

Ms. D, a 64-year-old unmarried Dominican, presented depressed and anxious over her 24-year-old daughter's desire to move in with her longstanding boyfriend. Living with her 3 sons, Ms. D experienced her daughter's wish to move as a great clash and dishonor (*un gran choque y deshonor)*. Her distressed sense of loss exacerbated a depressive episode previously responsive to medication.

Ms. D could not discuss her feelings with her daughter, who should know better than to dishonor and discount all the sacrifices (*descuenta mis sacrificios*) she had made to raise her, and recognize the shame it would bring her family name and status here, in the Dominican Republic, and in the culture (*la vergüenza a la familia, estatus en la comunidad aquí y en Sto. Domingo y nuestra cultura*). The therapist defined an intergenerational role dispute.

Interpersonal psychotherapy adaptations included explaining the role dispute as combining 2 cultural processes that Ms. D, as an immigrant, could understand: acculturation and intergenerational conflicts. Ms. D and the therapist discussed Ms. D's feelings about identifying with her daughter as, like herself, trying to pursue a better life as a minority in the majority culture while maintaining her cultural identity. Ms. D expressed hurt, anger, and sadness. After role-playing to bridge the acculturation divide, she began finally to convey these feelings to her daughter. As their communication improved, so did her depression. Ms. D grew to understand her daughter's wishes while expressing her maternal concerns.

Intergenerational conflicts may arise as migrant parents react to behaviors of more acculturated children, who tend toward greater individualism than is typical in Latin American cultures.

Ms. E, a 51-year-old single Dominican woman, reported lifelong depression exacerbated when mounting anxiety after the September 11 attacks cost her her job. Four months before she entered treatment, Ms. E's adult daughter and the daughter's husband left her apartment for a town 90 minutes away. Her 2 sons having already moved away, Ms. E was living alone for the first time.

Exemplifying the Hispanic maternal role, Ms. E described her children as her life's focus. Adaptation to an "empty nest" was painful: she feared her children would no longer need her, and would thus abandon her. Furthermore, airplane phobia after the September 11 attacks had prevented visiting her family in the Dominican Republic. Her last visit, 2 years before, required hospitalization in the Dominican Republic after she panicked on the plane. She felt isolated and nearly housebound by anxiety and depression.

Ms. E agreed to work on the role transition of reshaping relationships with her children in order to spend time together, enjoy her grandchildren, and also allow her children to help her. Therapy explored her options for maintaining and extending family contacts. In week 8, she accepted her daughter's invitation for a 2-day visit, during which she felt happy and comfortable. Fortified by this success, Ms. E planned a 2-week holiday visit to her daughter's home, with the option of flying to the Dominican Republic to visit 2 sick siblings. She discussed travel contingencies in therapy and, despite anxiety, took the flight. She felt relieved to realize she could return to the Dominican Republic and soothed that she retained contact with her siblings. Visiting her daughter and grandchildren bolstered her mood. Calmer and more optimistic, Ms. E planned monthly 2–3 day visits to her daughter, felt less isolated, and communicated better with her children.

Following acute treatment, Ms. E continued monthly maintenance sessions for 1 year. Symptoms and functioning further improved. She expressed interest in volunteering in health care and speaking about the benefits of psychotherapy.

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The IPT role transition framework neatly fit the developmental family dispersion its matriarch faced. This case again highlights the sacrificial role of Hispanic mothers and illustrates the difficulty surrounding even developmentally expectable family separations such as married children leaving home. Whereas IPT might focus a comparable Anglo patient on gaining independence and pursuing personal interests, it here reshaped Ms. E's family relationships to provide nurturance and support differently than before. Consistent with IPT theory, losing social supports worsened Ms. E's mood and regaining them relieved it. Through treatment, she gained some mastery of her environment, mobility, and confidence in asserting her needs within the family.

Gender Roles

Despite the persistence of *machismo,* women often wield power in Hispanic relationships. Women carry honor and status as defenders of the family and responsibility for preserving order and keeping the family unit intact. Engaging these roles in psychotherapy requires sensitivity both to general cultural norms and to individuals' and couples' specific experience.

Mr. F, a 59-year-old immigrant naturopath and Christian missionary, presented saying his "path in life" was disturbed. Once a strong, virile, admired man in Venezuela, he felt now weak and frustrated, victimized by the "cold, callous, and self-serving" people surrounding him in the United States. Mr. F explained this role transition resulted from immigration and a car accident shortly thereafter, which had injured his back. The therapist found it challenging to elicit Mr. F's feelings about this transition for 2 culturally related reasons. Mr. F avoided discussing his feelings because they entailed the unappealing, culturally dystonic role of a weak man unable to provide for his family. Mr. F also revealed that discussing his feelings would contradict his strong ability to *creer en Dios* (believe in God), "in Whose hands matters lie." The therapist subsequently facilitated his expressing emotions within the context of Biblical passages and exegeses. Discussing his immigration experience and perceived social injustice freed Mr. F from feeling trapped and enabled him to explore options and act to solve his immediate life problems. By week 12, Mr. F had begun volunteer work caring for the elderly and had begun delivering sermons over a local Hispanic religious radio station. De-emphasizing the medical model for this naturopath, who held distinct beliefs about health, and integrating his religious beliefs in the treatment approach were important in orienting Mr. F to therapy and facilitating expression and communication of distress.

Mr. G was a 32-year-old undocumented immigrant in a chronically strained marriage of mutually failed cultural gender roles. Depressed, he worked irregularly, failing in his role as family provider. He felt guilty not supporting his children in the United States and Mexico. Mr. G could not accept his wife's sexual abuse by and loss of virginity to a cousin during her teen years. He worried that she had enjoyed past sexual experiences more than being with him. To Mr. G, she had failed the role of "pure" woman. He doubted her fidelity and whether their daughter was his biological child.

Treatment explored Mr. G's response to work feedback. As any criticism affronted his masculinity, he repeatedly quit jobs, with resultant lengthy unemployment he felt guilty about. Treatment explored other ways in which he was a good father/provider and strategies for negotiating with employers.

Therapy also focused on the marital role dispute, Mr. G's feeling inadequate as breadwinner and about his wife's sexuality. The goal was to improve communication to help the couple recognize how their disputes affected their relationship and his depression. Never having discussed it, he believed his wife willingly participated in her abuse and could not understand its having continued secretly for years. He role-played, discussing how her sexual experience worried him about satisfying her sexually. While admitting that his jealousy was *machista*, Mr. G felt deceived at not having known her sexual history when they courted. By session 6, the couple discussed the past abuse and he acknowledged his wife's victimization. His mood subsequently improved.

In both cases, the men's gender role expectations, which ranged from personal virility to more extreme masculinity, crucially influenced the role transition and dispute contributing to the depression. Interpersonal psychotherapy engaged these expectations by exploring culturally-syntonic ways to develop a more desirable gender-based sense of self within cultural bounds.

Need to Avoid Humiliating or Irrevocable Social Confrontation

Interpersonal psychotherapy encourages elicitation, validation, and expression of feelings. Many depressed patients suppress and avoid anger, which IPT therapists normalize as a healthy signal of interpersonal conflict ("It means someone is bothering you"). They encourage patients to express such feelings directly: "I'm angry about how you've been treating me."

Our Hispanic patients often considered confrontation unacceptable, especially within the family. They considered directly expressed conflict offensive to all involved; expressing negative affects seemed cold and uncaring, rather than candid. That confrontation might permanently mar relationships outweighed the possibility that direct discussion might ameliorate disputes. Unlike in English, the Spanish *discusión* connotes "argument." Since expressing feelings to negotiate disputes is a central IPT technique, we normalized anger as a useful interpersonal signal, but tried to help patients to find less

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confrontational, culturally acceptable expressions. This was crucial for female patients facing difficult male relatives.

Ms. H, a 28-year-old married Mexican indigenous mother, reported MDD lasting 6 months, since an injury disabled her husband. She felt pressure to work herself, a task complicated by her lack of skills, English proficiency, and documentation. Beyond this economic role transition, a lengthier marital role dispute emerged. Afraid of marital disruption if she disagreed with her husband, Ms. H avoided arguments through silence (*Me quedo callada*—"I keep quiet"). This behavior reflected traditional Hispanic and indigenous values of maintaining family harmony. Her wifely role required maintaining a positive emotional family climate.

Interpersonal psychotherapy's emphasis on emotional responses in interpersonal encounters, and their expression both in sessions and with significant others, were challenging for Ms. H. Indigenous women are often socialized to suppress emotional expressions, privately and publicly.[40] Finances limited phone contact with tribal community, mother, and siblings in Mexico, with whom she could be somewhat more expressive. This exacerbated her depression. Her therapist, also an indigenous woman, modeled acceptable emotional expression for avowing love for her husband and desire for familial harmony. The therapist flexibly extended scheduling IPT sessions to allow trust to develop and to allow Ms. H an opportunity to gradually accommodate a communication style incongruent with her traditional culture. As communication increased, depressive symptoms receded. She remained jobless as termination approached.

Equanimity in Facing an Unpredictable Environment

The unpredictability of the new country complicates immigration. Many aspects of life once taken for granted no longer can be. Different customs, different language, and other changes constitute a culturally disorienting role transition. Such changes, while not specific to Hispanic immigrants, strongly affected patients' experience. Patients had limited economic resources and lived in violent, high-crime, drug-ridden neighborhoods. They may mistrust or be misunderstood or mistrusted by civil authorities, including the police. Touted escape routes from poverty, such as English classes and educational opportunities, appear unavailing. Life feels, and in respects really is, precarious. Individuals may feel overwhelmed and helpless confronting such stressors.

Hispanic patients often face this instability with a stoicism we generally view as a resilience akin to mindfulness,[41] although others have called it *fatalismo*.[42] *Resignación* has a positive religious overtone that its English cognate lacks: you must live with certain things you cannot change. The goal is to bear adversity with equanimity (*tranquilidad*), rather than harming oneself and others by immaturely demanding what cannot be. Depression may shift this outlook to negativism or nihilism. Interpersonal psychotherapy counters by appealing to resiliency ("Things are very hard and upsetting, but let's not let it keep you from responding") or justified anger, and helping patients to achieve "success experiences" that convey a sense of mastery over their environments.[19]

Ms. J, a 44-year-old undocumented Dominican immigrant, developed MDD along with cardiopulmonary deterioration contracted from 9/11-related clean-up work. A single mother who held 2 jobs before the September 11 attacks, Ms. J had become a heart transplant candidate, unable to climb stairs without dyspnea. With financial decline came eviction threats.

A role transition focused on Ms. J's response to adversity. She previously had refused to sue her verbally and sexually abusive ex-husband. She excused her recent employers, a cleaning company that provided insufficient protective gear at Ground Zero. She tried "not to think" about an acquaintance who months before had taken her money as deposit on an apartment that had never materialized. Because these were events "nobody wanted to happen," Ms. J felt it unfair to blame others. She attempted to reduce her anxiety and anger through willed equanimity, using this to ward off possible despair and the risk of even going crazy (*volverse loca*). She believed the problem, if ignored, would go into hiding (*se esconde*). Yet her self-control (*autocontrol*) faltered and she frequently became irritable, which distressed her.

Her therapist supported an alternative coping strategy Ms. J tentatively suggested: discussing her feelings about her life transition in order to unburden herself (*desahogarse*). The therapist linked her irritability to unprocessed anger, which she had not previously connected. Easiest to access was anger toward the friend who had absconded with her deposit. This exploration evoked other frustrations and disappointments. In 12 weeks she progressed well, and no longer met MDD criteria at termination.

Cultural adaptation required charting a middle course between the patient's competing cultural views: that equanimity was essential to her physical and mental health, and that "negative" emotions, when bottled up, produce disease. Through sustained attention to her interpersonal relationships and use of role-play, Ms. J eventually identified one person toward whom she felt able to express some anger, the friend. Focusing on this neither too close nor too distant relationship allowed her to experience relief in expressing feelings (*desahogarse*) in the safety of therapy without threatening her overall equanimity. From this beginning, therapy progressed to other situations in which strong emotions threatened Ms. J's *tranquilidad* and contributed to depression: her occupational exposure, lack of financial resources, and physical illness. Resultant symptomatic relief reinforced her commitment to self-expression in therapy and permitted exploration of expressiveness in other situations.

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DISCUSSION

Interpersonal psychotherapy appeared feasible and plausible for impoverished monolingual Hispanic patients in New York City. Focusing on relationship issues consonant with Hispanic cultures, IPT seemed flexibly adaptable to cultural tensions that arose. Cultural adaptations incorporated cultural experience—maternal role, spirituality, acculturation—to help patients understand interpersonal problem areas and gradual, modeled expression of emotion while preserving equanimity. We subtly changed the IPT model for some patients. At times we de-emphasized (without omitting) the medical diagnosis of depression, stressing instead the focus on interpersonal relationships. Some patients interpreted the medical language as indicating a permanent, stigmatizing affliction of the nervous system, precisely the interpretation the model is intended to avoid. We presented IPT using resonant cultural idioms, such as *desahogarse* to describe unburdening oneself of painful emotions and *poner de su parte* (the need to do one's part) to encourage patient agency in confronting or resolving conflicts. Therapists built a cultural exploration and formulation into the early, anamnestic treatment sessions, decoding in the interpersonal inventory[19,20] what relationships meant within the patient's cultural context. These cultural issues deserve scrutiny as potential mediators of outcome in future effectiveness studies of IPT and other treatments.

Patients welcomed psychotherapy and quick results, but were unfamiliar with time-limited treatment. Some, accustomed to long clinic waits, struggled to attend regular weekly appointments. Others perceived a time limit as potential abandonment. Coming from intensely social cultures, patients saw therapy as a relationship they did not expect would end. Therapists provided an orientation to therapy by educating patients about time-limited psychotherapy at the outset and acknowledging that it differed from usual handling of problems in their social network. Therapists reassured, "As we work together, I'll check in with you to see how you feel about the process and how our work fits with your world outside the office." Nonetheless, termination was sometimes difficult, and IPT was sometimes extended beyond the initial time frame.

Many depressed patients desperately needed concrete resources and related their distress to lack of housing and other needs. They saw their therapists as more successful, better integrated into mainstream culture, and better positioned than they to acquire these goods. Patients therefore often appeared passively resigned, expecting therapists to resolve their claims or to direct them, rather than to have to act themselves. They often seemed unable to navigate (English) procedures for obtaining needed benefits. Depression magnifies such passivity. The precariousness of patients' environments furthered some therapists' wishes to make suggestions or referrals for concrete services.

Obtaining needed services might indeed relieve environmental stress, yet psychotherapy typically arms patients to achieve such goals themselves. Thus therapists, without rejecting patients' requests, focused on the patient's role in IPT, including working to regain health.[19] Although occasionally offering concrete advice, therapists predominantly asked what patients had already tried, and what options remained to try, in order to meet their needs. Role-playing viable options then prepared patients for attempting them.

Some emerging cultural issues were not unique to Hispanics. Religiosity powerfully supported many patients, and influenced some patients' perceptions of environmental control. Some (e.g., evangelical and Catholic charismatic) churches encouraged activity and "greater involvement with brethren." More traditional Catholic patients often invoked "God's will" and stoic suffering. "God has a plan" expressed the passive aspect of *resignación*. Similarly, stigma about psychiatric treatment—our hospital was dubbed the "Building *de los Locos*"—is strong in many Hispanic communities, but not specific to them. Some New York Hispanics believe regular psychotherapy attendance betrays weakness, dependence, or risk of going crazy.

Therapists struggled with cultural issues. Should the therapist help an unassertive Latina develop self-assertion that might be beneficial outside the community but less culturally tolerated within? Abstracting clinical principles from nuanced cases without stereotyping was difficult. Culture interacts complexly with socioeconomic status, education, religion, migration, and other social phenomena. Differences among Central American, South American, and Caribbean Hispanic cultures, and indigenous cultures of Latin America, may require further exploration.

As noted, our adjustment of IPT to this treatment population did not derive from published frameworks for adapting empirically supported treatments,[10–12,14–17] but reflected the input of an ongoing "focus group" of experienced clinicians attempting to better understand and conform IPT to this subculture of Hispanics in New York. Accordingly, it is not a full-scale adaptation, but an initial foundation for developing and testing one. Other clinical teams might attempt the same approach elsewhere. Based on the psychotherapy adaptation literature, some general principles applied in our work might generalize to other minority cultures in other parts of the world, including orientation to therapy, using cultural bridges and metaphors, understanding culturally influenced models of illness, framing treatment concepts within cultural beliefs, and treatment in the patient's native language.[16,17,43,44]

For example, immigration to the United States, a stressor many of our patients faced, distinguished their situation from patients born in this country. It is not a unique stressor, as all immigrants share it. Yet differences may

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exist: other immigrant groups might respond with different coping mechanisms, based on their own cultural values, the dissonance of those values with the dominant culture, language differences (cf., Canadian to Mexican immigrants to the United States), prejudice, socioeconomic status, etc. Thus Vietnamese immigrants to the United States might face overlapping but subtly different pressures resulting from immigration and might respond to them differently.

Measuring cultural effects can be a subtle business. In any clinical encounter, therapists need to be aware of their own feelings and prejudices as well as patients' diagnoses, character, and cultural and socioeconomic backgrounds. These factors have differing impacts in different cases, requiring therapists to respond sensitively and flexibly, and complicating generalization about what "works" with a particular cultural population. Every adaptation of IPT has required determining the salient issues of the treatment population, which vary among depressed adolescents, depressed geriatric patients, and depressed HIV-positive patients, for example. Similarly, IPT with Spanish-speaking immigrants in New York City likely differs slightly from IPT with, say, Scandinavian or Ugandan patients.[45,46]

Interpersonal psychotherapy appears sufficiently flexible to maintain its general structure, with some adjustment, with varied patients. Further steps toward a formal adaptation would include testing our initial clinician-focused group adaptation using qualitative research with patients/family members and community experts, then revising and iteratively developing a manualized version of IPT for Hispanics using quantitative and qualitative assessments with patients, clinicians, and experts in IPT.

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