

Equity and Inclusion in Prevention: Depression Prevention in Black and White American Youth

Hayley D. Seely and Patrick Pössel

Department of Counseling and Human Development, University of Louisville

Objective: Depression is an ongoing public health issue impacting over 5 million American adolescents. Although prevention has been shown to be an effective strategy in reducing the incidence of depressive symptoms, depression prevention programs have been developed and tested in largely White populations. Thus, the effects of such programs in diverse groups are understudied, though research shows adapted versions are more beneficial for diverse populations than nonadapted programs. In this study, we sought to examine the effects of depression prevention in Black and White American youth. **Method:** Informed by youth focus groups, we adapted and implemented a program which previously benefited mainly White samples to benefit Black and White American inner-city high school students. Of the 425 youth who participated, 57.2% identified as Black and 42.8% identified as White. We randomized youth into two conditions—prevention and nonprevention control—and measured depressive symptoms over three semesters. **Results:** We found differential effects of prevention on Black and White American youth. For Black American youth, there was no difference between the two conditions at any of the waves of data collection. For White American youth, however, the prevention program worked as intended. **Conclusions:** Given our findings and past research, it is essential to investigate possible causes for the differential effects of prevention to increase understanding and ensure positive effects of prevention for all youth. Additional ramifications and recommendations for future research and practice are discussed.

What is the public health significance of this article?

This study highlights the importance of considering the limitations of our evidence base when working with racially diverse groups. Current depression prevention strategies appear to not meet the needs of Black American youth making ongoing research examining the reasons for racial differences necessary.

Keywords: prevention, depressive symptoms, adolescents, race, equity and inclusion

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Due to its high and growing prevalence (Centers for Disease Control and Prevention, 2023), adolescent depression has long been a frequent topic of research (see Beirão et al., 2020; Clayborne et al., 2019, for reviews). This research has clarified the ramifications of adolescent depressive symptomatology including increased risk of developing additional academic, social, and emotional concerns (Auerbach et al., 2010; Gorrese, 2016; Ogundele, 2018; Verboom et al., 2014), as well as long-term impacts such as missed work, impaired

academic and work performance, and burdened relationships (Andrews et al., 2004; Kessler et al., 2012; Naicker et al., 2013; Trautmann et al., 2016). Although numerous prevention programs and intervention strategies have been developed and empirically tested to diminish both the prevalence and long-term risks of depressive symptoms (see Cuijpers et al., 2020; Merry et al., 2011; van Zoonen et al., 2014, for meta-analyses), the effects of these programs in diverse populations are understudied. In fact, despite recent efforts toward

Pim Cuijpers served as action editor.

Hayley D. Seely  <https://orcid.org/0000-0001-8049-7923>

Patrick Pössel  <https://orcid.org/0000-0002-5851-4253>

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Correspondence concerning this article should be addressed to Patrick Pössel, Department of Counseling and Human Development, University of Louisville, 2301 South Third Street, Louisville, KY 40292, United States. Email: patrick.possel@louisville.edu

more inclusive and representative research, Black youth remain underrepresented, greatly limiting understanding of the effects of psychological intervention and prevention in this group (see Chowdhary et al., 2014; Wilson & Cottone, 2013, for reviews).

According to recent data from the Centers for Disease Control and Prevention (2023), 42% of youth reported experiencing depressive symptoms in 2021, marking a notable increase in youth depression over the past decade. While adolescent depression prevention has the potential to reduce the incidence of depression by 21% (van Zoonen et al., 2014), this remains an essential avenue of research as rates continue to rise. Cognitive behavioral therapy (CBT), specifically, has been highlighted by the American Psychological Association (APA, 2019) as a frontline approach given its strong evidence base both in adolescent depression prevention (see Brunwasser & Garber, 2016, for a review) and treatment (see Oud et al., 2019, for a meta-analysis). In terms of cultural responsiveness and cross-cultural application, CBT has also been shown to be an effective treatment modality for diverse groups (see Huey et al., 2023, for a review). However, trends in this research suggest that the benefits associated with CBT treatment may be less for diverse populations than for White populations (see Huey et al., 2023, for a review).

Despite the vast research base for CBT (APA, 2019; Brunwasser & Garber, 2016; Oud et al., 2019) and the small research base suggesting cross-cultural benefits (see Huey et al., 2023, for a review), effects for specific marginalized populations are an underexplored research area that is key given that culture and lived experience vary widely. Evidence for the effects of cognitive behavioral adolescent depression prevention in Black youth specifically is lacking due to limited representation in research (Perrino et al., 2015). In fact, to our knowledge, only one study investigates the effects of CBT-based depression prevention on Black youth (Cardemil et al., 2002, 2007). The authors of this study adapted a depression prevention program that has previously been shown to be beneficial for mostly White American youth (for a meta-analysis, see Brunwasser & Garber, 2016). This study illustrates differential effects of adolescent depression prevention on Black and Latino youth such that the program did not have a significant effect on the depressive symptoms of Black youth, whereas the program did have a significant effect for Latino youth.

Furthermore, research illustrates notable race-based differences in depression risk factors due to social positionality. Specifically, societal factors including discrimination (Lavner et al., 2023), intergenerational trauma (Hankerson et al., 2022), and socioeconomic status (Bryant-Davis et al., 2010) place Black youth at higher risk for depressive symptoms than their peers. The fact that differences in lived experience result in higher risk for Black youth suggests that prevention efforts benefiting Black youth are urgently needed. Research shows that studies conducted in White samples do not generalize to diverse populations (American Psychological Association Task Force on Race and Ethnicity Guidelines in Psychology, 2019). Therefore, intentionally adapting current, empirically supported programs to be used with Black youth is an important first step toward more inclusive and equitable care. Research suggests that, depending on the specific setting and the specific sample, culturally adapted interventions are usually associated with more benefits for diverse populations than traditional, nonadapted interventions (see Anik et al., 2021; Arundell et al., 2021, for reviews). Clearly, cultural adaptation shows promise; yet, there is still much to be learned about adapting evidence-based programs for diverse populations. It is through continuing to adapt evidence-based

programs and evaluating these adaptations, a central aim of the present study, that it is possible to begin identifying the effects of adapted programs toward research investigating specific mechanisms of change and, eventually, programs developed with the unique needs of diverse youth integrated. While these are long-term aspirations, it is necessary to begin developing a research base for prevention in diverse populations to lay the groundwork for such research.

The Present Study

There is a notable lack of Black representation in psychological research in general (see Chowdhary et al., 2014; Wilson & Cottone, 2013, for reviews) and prevention science specifically (Perrino et al., 2015). This, along with the distinct differences in lived experience that put Black populations at increased risk for depressive symptoms (Bryant-Davis et al., 2010; Hankerson et al., 2022; Lavner et al., 2023), makes investigating the effects of prevention in Black youth necessary. In the present study, we aimed to address this gap in research by investigating the effects of a culturally adapted evidence-based universal, school-based adolescent depression program in a sample of Black and White American youth. Informed by past research on the prevention program and on the benefits of adapting evidence-based programs, we hypothesized that the adapted program would benefit both Black and White American youth.

Method

Participants

Youth ($N = 637$) attending a Title 1 school where most students (86%; Jefferson County Public Schools, 2019) qualify for free or reduced lunch were recruited during ninth grade and followed over the course of three semesters. Due to the goals of this study, only youth identifying as Black or White were included. After participant exclusion, we were left with a sample size of 425 with most of the youth identifying as Black (57.2%; 42.8% identified as White). Youth ranged in age from 12 to 17 ($M = 14.37$, $SD = 0.75$). Over half of youth identified as girls (58.4%; 41.6% identified as boys).

Procedure

We implemented the below-described prevention program as part of the standard school curriculum for ninth grade students in an inner-city school in the Southern United States. Legal guardians of the ninth grade students received a written description of the evaluation along with a consent form when they enrolled their youth at the school. Students who received consent from their guardians were informed about the evaluation and given the opportunity to ask questions before they were assented.

Participating youth fell into one of two conditions: prevention and nonintervention control. Youth who took Physical Education in the fall or spring semester of their ninth grade participated in the prevention program. Youth who took this class in a later semester participated in the control condition during their ninth grade. We collected data at the beginning of the semester when the adolescents started to participate in the study (baseline), at the end of that semester (postprevention), and approximately 4 months later (follow-up). To limit participant dropout, our research team was permitted to identify students who were missing during the scheduled days of data

collection and pull them out of classes the following week to complete said data collection.

For those in the prevention condition, the prevention program was delivered following the baseline data collection. Due to the COVID-19 epidemic and the measures to control it, the data collection had to be stopped 1 year early which resulted in a smaller sample size as intended. Youth in the control condition participated in a standard school curriculum without the prevention program. Stratifying by race, the differential attrition rate was 12% or less across waves. See Figure 1 for full sample breakdown including attrition rates.

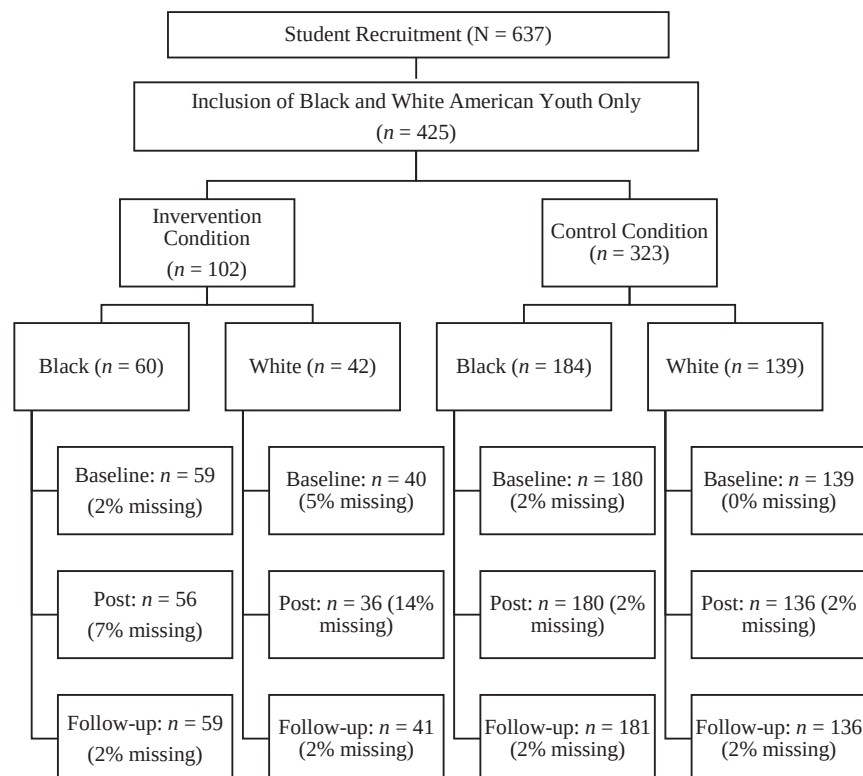
Youth in the prevention condition participated in a 10-week group program *Lust An Realistischer Sicht & Leichtigkeit Im Sozialen Alltag* (LARS&LISA; Pössel, Horn, Seemann, & Hautzinger, 2004), a prevention program in gender-homogeneous groups. Each session was composed of a 90-min block and was led by two group leaders. Group leaders were students in a mental health graduate program (i.e., counseling psychology, community mental health counseling, social work, art therapy). Each group ranged in size based on the size of the original classroom with the smallest group having three students and the largest group having 12 students ($M = 6.11$, $SD = 2.51$). We assessed group leader adherence to the program manuals by asking the group leaders to complete a self-assessment following each group session. These self-assessments consisted of completing a checklist of the content that was to be covered in the given session (e.g., “Slide 2.1/Worksheet 2.1: Set Some Goals,” “Slide 9.1: Up-Thought Game”) indicating if the content had been completely covered (2),

partially covered (1), or not covered (0). Although each group was led by two group leaders, each group leader completed these assessments independently so their reports could be compared. On average across sessions, group leaders rated their adherence as 1.61 ($SD = 0.25$). Interrater reliability across all sessions was $r = .85$. We also asked group leaders to rate youth in terms of attendance (0 = did not attend; 1 = did attend), engagement (0 = no or little participation in session; 3 = high participation in session), and distraction (0 = no disruption to group process or distracting for other participants; 2 = behavior is consistently disruptive to the group process or distracting for other participants). On average across sessions, youth attended 72% of the sessions, and group leaders rated youth engagement as 2.23 ($SD = 0.70$) and disruption as 0.42 ($SD = 0.41$). Interrater reliability across all sessions for attention, engagement, and distraction was .98, .94, and .86, respectively.

Experimental Design and Intervention

LARS&LISA is a universal, school-based, adolescent depression prevention program originally developed in Germany (Pössel, Horn, Seemann, & Hautzinger, 2004) and previously successfully implemented and evaluated in Germany and America (see Pössel et al., 2018, for review), with evidence suggesting related improvements in depressive symptoms (Pössel et al., 2011, 2013) as well as aggression (Groen et al., 2003), hyperactivity (Seely et al., 2023), and social functioning (Pössel et al., 2003; Seely et al., 2023).

Figure 1
Flowchart Describing Sample Size and Attrition From Baseline to Follow-Up Separated by Condition and Race



The program demonstrated to be effective independent of comorbid symptoms of anxiety and conduct problems (Pössel et al., 2008) and in youth with and without migrant background (Pössel et al., 2022).

The LARS&LISA program integrates elements of self-management therapy (Kanfer et al., 1996) and cognitive behavioral therapy (Beck et al., 1979). The first two group sessions use Kanfer et al.'s (1996) self-management therapy to build motivation in the youth by working with them to set personal goals. The purpose of this element is to encourage the youth to actively participate in the following program elements. In the following program elements, the group leaders work with the youth to help them understand how they can use the content of each following program element to accomplish their goals. The aim of the next four-session long program element is designed to help the youth recognize the associations between thoughts, feelings, and behaviors. Youth learn how to recognize unrealistic and/or unhelpful thoughts, to question those thoughts, and to replace them by more realistic and helpful thoughts (Beck et al., 1979). The remaining four sessions focus on how to identify and implement assertive communication as well as how to make friends (Beck et al., 1979). The two main characters, Lars and Lisa, and their friends are used in stories and role-plays to teach the content of the program elements, demonstrate how to use the skills in difficult situations, and change and replace unrealistic and/or unhelpful thoughts and behaviors. Youth also practice their new skills in the form of role-plays and discuss when and where to apply these skills in their lives. More information about LARS&LISA, the theoretical basis, and previous evaluations can be found in Pössel et al. (2018).

To adapt LARS&LISA from a previously evaluated program with mainly White American suburban youth (Pössel et al., 2013) for use with Black and White American inner-city youth, we held multiple focus groups with youth who participated in the program. We intentionally elicited feedback from Black and White youth by holding separate focus groups and discussing elements of the program that could be improved. The adaptations included the replacement of culturally inappropriate scenarios and more fundamental changes (for details of the adaptations, see online [Supplemental Material](#)).

Measures

Demographics

We asked youth to report their age, gender, and race via a demographic survey.

Center for Epidemiological Studies–Depression Scale

We utilized the Center for Epidemiological Studies–Depression Scale (CES-D; Radloff, 1977) to gather youth report of depressive symptoms. This 20-item questionnaire has been identified as an effective screener for depression in youth samples (Garrison et al., 1991). Youth are asked to share frequency of depressive symptoms in the past week by responding to items (e.g., “I was bothered by things that usually don’t bother me”) on a 4-point Likert-type scale (0 = *rarely or none of the time*; 3 = *most or all of the time*). Reverse coding was used for positive valenced items (e.g., “I felt I was just as good as other people”) so that higher scores indicate more depressive symptomatology. A sum score was calculated with higher scores reflecting more reported depressive symptoms. In our

sample, the internal consistency reliability is .83 and .92 for Black youth and White youth, respectively.

Transparency and Openness

We report all data collection procedures, manipulations, and measures used for the purpose of this article, and we follow the Journal Article Reporting Standards (Appelbaum et al., 2018). All data, analysis code, and research materials for this study are available by emailing the corresponding author. Data were analyzed using SPSS. This study was registered as a clinical trial at the time of its development (NCT03831139); a trial protocol has not been previously published. Approval was obtained from the Institutional Review Board of the University of Louisville and the public school district to which the high school belongs (Institutional Review Board number: 15.0318).

Data Analysis

As the prevention program was implemented in groups, the interclass correlation coefficient was conducted to assess the need for multilevel modeling considering groups as a nesting variable. However, the interclass correlation coefficient was nonsignificant, suggesting linear regression and not multilevel modeling to be appropriate (Garson, 2020). To examine our hypotheses, we utilized a three-way repeated measures regression. All assumptions of linear regression were met in our data set. We used CES-D scores as the within-subjects variable to map reported depressive symptoms over the course of three waves. We used condition (prevention and nonprevention control) along with race as between-subject predictors of depressive symptoms over time. As these analyses resulted in three-way interactions, we probed the analyses by investigating the effects of time and the interaction between time and condition within race, followed by examining the effects of time within race within condition. In cases of missing data, pairwise deletion was utilized.

Results

Study population characteristics can be found in [Table 1](#), and descriptive statistics of major study variables can be found in [Tables 2 and 3](#). At baseline, the youth in the control condition and the prevention condition differed in regard to age with those in the control condition being significantly older than those in the prevention condition, $t(422) = 4.82, p < .001$, but did not differ in terms of gender, $\chi^2(1, N = 422) = 0.34, p = .558$, race, $\chi^2(1, N = 425) = .109, p = .741$, nor reported depressive symptoms, $t(416) = 0.69, p = .493$. Reports of depressive symptoms were highly correlated between waves for both Black American youth ($r_{\text{range}} = .61-.77$) and White American youth alike ($r_{\text{range}} = .65-.88$). Additionally, condition was not significantly correlated with reported depressive symptoms postprevention ($r = -.008$) nor follow-up ($r = -.022$) for Black American youth, but for White American youth (postprevention: $r = -.25$; follow-up: $r = -.23$). This difference in the effects of the prevention program for Black American youth as compared to White American youth was then further supported in our repeated measure analyses where three-way interaction between time, condition, and race emerged, $F(1.75, 698.88) = 4.54, p = .015, \eta^2 = .011$; see [Table 4](#) for all repeated measures analyses. In probing this three-way interaction, we found

Table 1
Demographic Variables of Youth Separated by Condition

Variable	Control condition	Prevention condition	Total sample
Age	$M = 14.46$ ($SD = 0.79$)	$M = 14.05$ ($SD = 0.50$)	$M = 14.36$ ($SD = 0.75$)
Gender			
Girls	57.5% ($n = 184$)	60.8% ($n = 62$)	58.3% ($n = 246$)
Boys	42.5% ($n = 136$)	39.2% ($n = 40$)	41.7% ($n = 176$)
Race			
Black	57.0% ($n = 184$)	58.8% ($n = 60$)	57.4% ($n = 244$)
White	43.0% ($n = 139$)	41.2% ($n = 42$)	42.6% ($n = 181$)
Baseline CES-D	$M = 15.70$ ($SD = 10.58$)	$M = 14.85$ ($SD = 11.26$)	$M = 15.50$ ($SD = 10.74$)

Note. All reported variables were collected during the baseline data collection. CES-D = Center for Epidemiological Studies–Depression Scale.

no significant benefit of prevention for Black American youth as compared to their peers in the control group, $F(1.86, 429.92) = 0.41$, $p = .652$, $\eta^2 = .002$. However, for White American youth, there was a significant Time $\times$ Condition interaction, $F(1.58, 265.34) = 10.04$, $p < .001$, $\eta^2 = .056$, such that depression prevention was related to fewer depressive symptoms following implementation of the prevention program as compared to their peers in the control group. Specifically, as shown in Figure 2, White American youth in the prevention condition reported significantly fewer depressive symptoms postprevention, $F(1, 170) = 11.69$, $p < .001$, $\eta^2 = .064$, and at follow-up, $F(1, 175) = 9.87$, $p = .002$, $\eta^2 = .053$, than those in the control condition (see Tables 4 and 5).

Discussion

With the ever-expanding reach of depressive symptoms (Centers for Disease Control and Prevention, 2023) and the lack of diverse representation in research (American Psychological Association Task Force on Race and Ethnicity Guidelines in Psychology, 2019), research investigating the effects of evidence-based treatment and prevention for depression is timely. In line with past research (Cardemil et al., 2002, 2007; see Huey et al., 2023, for a review), we found that the culturally adapted evidence-based universal, school-based adolescent depression program had no significant effect on Black American youth, whereas there was a significant effect for White American youth. In fact, for White youth, the program worked as intended with significant effects following program implementation for those in the prevention condition.

While disappointing, our findings are not surprising as current literature suggests that even when programs are effective for diverse populations, they experience less benefit than White populations (see Huey et al., 2023, for a review). Furthermore, the only other research we are aware of that investigates the effects of depression prevention on Black American youth found similar results with no significant benefit for Black youth (Cardemil et al., 2002, 2007), while Latinx American youth benefited from an adapted version of an evidence-based prevention program. Taken together, the present study and past research calls into question what is being missed in current cultural adaptations. Overall, it seems that adapted depression prevention programs are not working as intended for Black youth. There are many potential reasons for this, all of which should be explored in future research.

First, our study and Cardemil and colleagues' research focuses on low-income populations. Notably, past research has identified youth in low socioeconomic environments to be at higher risk of depression and to experience more pervasive depressive symptoms (Lemstra et al., 2008; Lorant et al., 2003). Therefore, the argument could be made that the utilized prevention program is targeted prevention instead of universal prevention leading to "therapy effects" in place of "prevention effects" (Pössel, Horn, Groen, & Hautzinger, 2004). In other words, one might expect that the depressive symptoms in the intervention group decrease over time like it is typical for therapy studies instead of the depressive symptoms of the control group but not the intervention group increasing over time which would be typical for (universal) prevention studies. Furthermore, as intersectionality plays an

Table 2
Bivariate Correlations, Means, and Standard Deviations of Major Study Variables Separated by Race

Measure	Separated by race				M (SD)
	1	2	3	4	
1. Condition	—	.004	-.008	-.022	
2. CES-D W1	-.07	—	.66***	.61***	14.62 (9.90)
3. CES-D W2	-.25***	.70***	—	.77***	15.67 (9.80)
4. CES-D W3	-.23***	.65***	.88***	—	15.75 (10.15)
M (SD)		16.66 (11.69)	16.34 (11.43)	16.73 (11.76)	

Note. Scores for Black American youth ($n = 244$) are displayed above the diagonal; scores for White American youth ($n = 181$) are displayed below the diagonal; CES-D = Center for Epidemiological Studies–Depression Scale; W1 = baseline data; W2 = postprevention data; W3 = follow-up data.

*** $p < .001$.

Table 3
Bivariate Correlations, Means, and Standard Deviations of Major Study Variables Separated by Condition

Measure	Separated by condition				<i>M (SD)</i>
	1	2	3	4	
1. Race	—	-.118*	-.097	-.103	
2. CES-D W1	-.017	—	.780***	.690***	15.70 (10.58)
3. CES-D W2	.258*	.314**	—	.826***	16.62 (10.80)
4. CES-D W3	.190	.436***	.789***	—	16.88 (11.23)
<i>M (SD)</i>		14.85 (11.26)	13.65 (9.14)	13.89 (9.25)	

Note. Scores for youth in the Control condition ($n = 323$) are displayed above the diagonal; scores for youth in the Prevention condition ($n = 102$) are displayed below the diagonal; CES-D = Center for Epidemiological Studies–Depression Scale; W1 = baseline data; W2 = postprevention data; W3 = follow-up data.

* $p < .05$. ** $p < .01$. *** $p < .001$.

important role in the lived experience of individuals (Crenshaw, 2005), it is possible that the intersection between race and socioeconomic status for Black youth specifically is contributing to the lack of effect. Similarly, it may be that adaptations are effectively considering aspects of this intersection but that important pieces are missing. To continue addressing this in future research, paid focus groups and participant involvement in the adaptation and development of prevention programs are recommended. Additionally, it would be meaningful to replicate this study in an affluent school with Black and White students to test this hypothesis regarding the role of intersectionality in the lack of effect for low-income Black youth and to further bolster the effects of this prevention program when used as universal prevention. Finally, continuing to increase diverse and multicultural perspectives in the field of psychology and in prevention science research specifically is key.

Another factor that may be contributing to our results is potential differences both in lived experiences and contributing symptomatology. The most well-known and applied theories of depression were conceived by White researchers (e.g., Abramson et al., 1989; Beck, 1976) and largely validated with White populations (Abela & Hankin, 2011; Marchetti et al., 2021). Therefore, whether or not these theories can be generalized to diverse population is unknown. As far as we know, only one study examined if, and to what degree, cognitive vulnerability theories of depression developed on largely White samples apply to Black youth. Using network-analyses, this study

illustrated the association between attribution style and depressive symptoms to be less strong in Black American youth than in White American youth (Pössel et al., 2024). Based on this study and our own findings, future research should investigate this by testing the relevance of proposed cognitive factors such as negative cognitive style (Abramson et al., 1989) and dysfunctional attitudes (Beck, 1976) in depressive symptoms for Black youth.

In addition to presenting many potential research avenues, our findings have important implications for how evidence-based prevention is applied. Specifically, clinicians implementing prevention programs specifically should be aware that depression prevention studies have yet to illustrate significant effects for Black youth. In other words, as the American Psychological Association Task Force on Race and Ethnicity Guidelines in Psychology (2019) stated, given the wide discrepancy in the psychological experiences of diverse populations, it is essential to be attentive to cultural differences and not assume generalizability. This further highlights the importance of utilizing cultural humility and attending to cultural context both in research and practice (Hook et al., 2013).

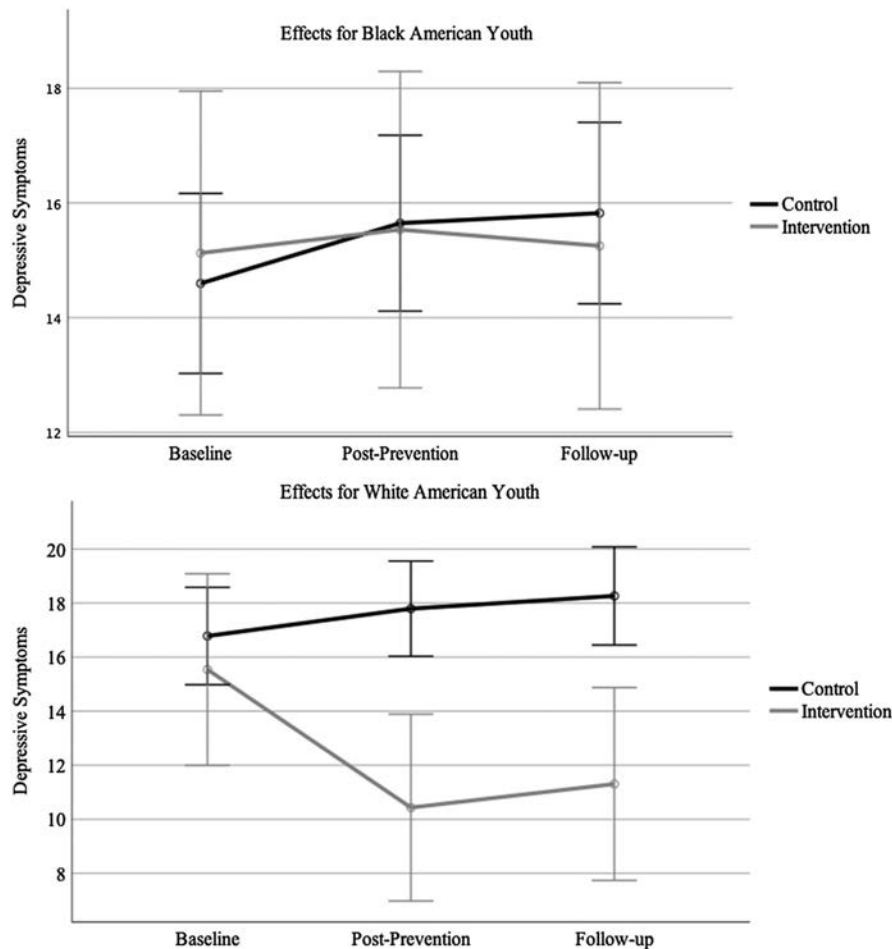
Strengths, Limitations, and Future Directions

In the present study, we recruited a diverse student population with Black American youth representing over 50% of our sample. This was key as our intention was to investigate the effects of adolescent depression prevention on Black American youth specifically.

Table 4
Repeated Measures Analyses Investigating the Effects of Condition and Race on Depressive Symptoms Over Time

Predictor variable	df_{effect}	df_{error}	F	p	η^2
Three-way analyses					
Time	1.75	698.88	0.91	.391	.002
Time $\times$ Condition	1.75	698.88	8.04	<.001	.020
Time $\times$ Race	1.75	698.88	4.34	.017	.011
Time $\times$ Condition $\times$ Race	1.75	698.88	4.54	.015	.011
Two-way analyses: Black American youth					
Time	1.86	429.92	0.88	.418	.004
Time $\times$ Condition	1.86	429.92	0.41	.652	.002
Two-way analyses: White American youth					
Time	1.58	265.34	3.73	.035	.022
Time $\times$ Condition	1.58	265.34	10.04	<.001	.056

Figure 2
Illustrations of Condition Effects Overtime Separated by Race



Note. Error bars illustrate 95% CI (confidence interval).

Additionally, this sample was collected from a Title 1 school where the majority of students qualified for free or reduced lunch increasing the generalizability of our findings to low-income students. We also utilized focus groups to adapt our program based on the feedback of Black and White youth. This meant that youth voices informed the adapted program. Implementing the prevention program in two

conditions (immediate and delayed) is another strength as we were able to demonstrate that the participation in the program and not other confounding variables (e.g., season, time since beginning of the school year) are associated with a reduction in depressive symptoms.

As with all research, our study also has limitations that are important to consider. The role of supervised group leaders is both a strength and limitation. On one hand, supervision is shown to improve manual adherence (Anderson et al., 2012). On the other hand, this ongoing supervision may not be sustainable or replicable given the additional resources (i.e., clinical supervisors) necessary to provide this supervision, thus limiting generalizability. Further limiting generalizability, we collected data from only one school, with one prevention program, and have a relatively small sample size. Although this sample allowed for inclusivity of racially and socioeconomically disadvantaged youth, it may not generalize to other populations. Related to the selected prevention program (LARS&LISA), although our findings are consistent with research illustrating differential effects of adolescent depression prevention on diverse youth (Brunwasser & Garber, 2016; Cardemil et al., 2002, 2007), it is also possible that the effects we found here are

Table 5
One-Way Analyses Investigating the Effects of Condition on Depressive Symptoms Separated by Wave and Race

Wave separated by race	df_{effect} , df_{error}	F	p	η^2
Black American youth				
Baseline	1, 237	0.004	.949	.000
Postprevention	1, 234	0.02	.903	.000
Follow-up	1, 238	0.12	.732	.000
White American youth				
Baseline	1, 177	0.95	.331	.005
Postprevention	1, 170	11.69	<.001	.064
Follow-up	1, 175	9.87	.002	.053

specific to this particular prevention program and may not generalize to other programs. Further, we utilized only one outcome measure, the CES-D. Although adolescents are shown to be reliable sources related to their own mental health (Hops et al., 1997; Inderbitzen, 1994) and the CES-D is an extensively studied measure in psychological research that meets reliability and validity standards (Blodgett et al., 2021; Vilagut et al., 2016), it would be meaningful for future research to incorporate parent or teacher reports as well as other measures of depression as recommended by Smith (2023) to further bolster the findings presented here.

Conclusion

Following the American Psychological Association Task Force on Race and Ethnicity Guidelines in Psychology's (2019) statement regarding the lack of generalizable research, in this study we sought to investigate the effect of a culturally adapted evidence-based universal, school-based adolescent depression program on Black and White American youth. While results illustrated the proposed prevention effect for White American youth, this benefit did not hold for Black American youth. These results, along with the limited research on depression prevention in Black youth (Cardemil et al., 2002, 2007), begins to suggest that even adapted prevention programs are not serving Black youth as intended. This calls upon prevention scientists to investigate the mechanisms of change for Black youth specifically to inform both adaptation and development of prevention programs as well as upon clinicians to continue being thoughtful in their utilization of evidence-based practice with culturally diverse populations.

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