

LEVERAGING IMPLEMENTATION OUTCOMES TO EVALUATE AND ELUCIDATE
THE CORE AND ADAPTABLE COMPONENTS OF THE *CULTIVATING RESILIENCE*
INTERVENTION FOR LATINX/HISPANIC IMMIGRANTS: A MIXED METHODS STUDY

by

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ABSTRACT

LEVERAGING IMPLEMENTATION OUTCOMES TO EVALUATE AND ELUCIDATE THE CORE AND ADAPTABLE COMPONENTS OF THE *CULTIVATING RESILIENCE* INTERVENTION FOR LATINX/HISPANIC IMMIGRANTS: A MIXED METHODS STUDY

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Under the Supervision of Dr. Gabriela Nagy

This study sought to assess and optimize the acceptability, appropriateness, and feasibility of the *Cultivating Resilience* (*Cultivando Fortaleza*, in Spanish) intervention for Latinx immigrants/Hispanics. To this end, the present mixed methods study leveraged existing theoretical implementation frameworks and a community-engaged approach in the pursuit of three aims. We first aimed to analyze quantitative data (e.g., ratings along implementation outcomes) derived from a multimedia survey administered to a national, multidisciplinary panel of individuals ($N=74$) with experience working in Latinx communities or expertise in the field of acculturative stress and/or implementation science. Second, in line with an explanatory mixed methods (QUAN → qual) design, we analyzed qualitative data extracted from two subsequent focus groups with members of our research team's Community Advisory Board ($N=10$) and the survey's open-ended feedback. Third, we relied on a pillar-building integration process to extract overarching themes. Results indicated high acceptability and appropriateness across *Cultivating Resilience* components as well as high feasibility across different modes and methods of delivery. Findings shed light on methodological considerations for refining core and adaptable intervention components to aid subsequent implementation efforts.

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LIST OF ABBREVIATIONS

AIM	The Acceptability Implementation Measure
CBPR	Community-Based Participatory Research
CBT	Cognitive Behavioral Therapy
EBI	Evidence-Based Intervention
FIM	Feasibility of Intervention Measure
FRAME	Framework for Reporting Adaptations and Modifications- Expanded
IAM	Intervention Appropriateness Measure
IOF	Implementation Outcomes Framework
PCIT	Parent-Child Interaction Therapy
PMT	Parent Management Training
RCT	Randomized Control Trial
US	United States

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Background

The Immigrant Paradox

Immigrants evidence a relative health advantage upon arrival to the United States (US) known as the *Immigrant Paradox* (also referred to as the *Health Immigrant Paradox* or *Hispanic Paradox*; Teruya et al., 2013). This phenomenon contradicts the disproportionate rates of poverty and systemic barriers shared by some sub-groups of Latinx¹ individuals (Velasco-Mondragon et al., 2016), observations that would otherwise suggest a significant health vulnerability in the population. The *Immigrant Paradox* has been attributed to and explained by many factors. Some research contends that the observed health advantage of immigrants in the US is illusory and indicative of immigrant migratory patterns underlying the *salmon hypothesis* (Pablos-Méndez, 1994). Specifically, this theory points to selective emigration tendencies that exist as immigrants return to their countries of origin when they become ill, leading to underestimated documentation of mortality for Latinx individuals who are then in effect, “statistically immortal”² in the US (Abraído-Lanza et al., 1999; Turra, 2008). Conversely, the *migrant health selectivity* theory (Crimmins et al., 2007) proposes that in the same manner that unhealthy individuals tend to leave the US, healthy individuals tend to migrate to the country, contributing to the health paradox.

A substantial body of research has instead focused investigations on the unique intrapersonal and interpersonal qualities that hallmark Latinx culture³ that may lead to enhanced

¹ Herein, we use the term “Latinx” to be a gender inclusive term synonymous with “Hispanic,” with the understanding that different personal and academic preferences may exist specific to this terminology (María Del Río-González, 2021).

² “Statistically immortal,” as it relates to the *salmon hypothesis*, refers to Latinx deaths that are not accounted for in US mortality statistics (Abraído-Lanza et al., 1999; Turra, 2008).

³ The literature in this space has at times inadvertently lacked sufficient specificity to capture nuances across distinct sub-groups of Latinxs taking into account vast heterogeneity. Herein, we include examples of culturally salient themes pertaining to Latinxs with the understanding that any time one describes group-level trends within a population, it may not apply to every single individual within that population.

resilience and health outcomes in this population. This includes evidence that Latinx immigrants often pursue healthier lifestyle choices (e.g., higher consumption of fresh fruit and vegetables, less sedentary lifestyles, and less substance use) compared to their non-Latinx counterparts and compared to Latinx counterparts who are more acculturated to American culture (Lara et al., 2005). Many salient traits have also been linked to the Latinx identity, including a collectivistic cultural orientation rooted in familism (Comeau, 2012). Collectivism, diametrically opposed to individualism, places a strong emphasis on group cohesion that for the Latinx community, often manifests into behaviors and values pertinent to the family unit. This cultural orientation has important implications for protective health factors; Latinx familism shapes social support networks that can ultimately serve to protect against health ramifications tied to being minoritized. This would be consistent with the broader literature which has historically magnified how both the multitude and magnitude of health outcomes are dictated by an individual's engagement with social support systems. For example, across several studies, those with stronger social ties have exhibited stark benefits in longevity, recovery, disease prognosis, and immune function in contrast to those with social networks that are deficient in quantity and/or quality (Cohen et al., 1997; Vila, 2021). Some of this literature has further suggested that these benefits hold true regardless of various vulnerabilities including stress intensity and presence of physical risk factors like smoking, poor eating habits, and high blood pressure (Costa-Cordella et al., 2021). These findings are compelling and conceivable when interpreted against the individualistic landscape of the US, which projects loneliness as an emerging "epidemic" (Office of the Surgeon General, 2023). Therefore, theories of this nature posit that the immigrant collectivistic identity functions to predict and protect health outcomes.

As immigrants reside in the US and maintain valuable social ties, they also may be mobilized by optimism in the “American Dream,” the general belief that the US can afford opportunity, freedom, and upward socioeconomic mobility with hard work; for the Latinx immigrant community, this optimism is considered a multidimensional construct that consists of the hope for a better future, for economic opportunity, and for freedom and safety (Cervantes et al., 2022). According to a Pew Research Study (2018), 77% of Latinxs expressed the belief that they can get ahead with hard work compared to the US general public (62%). Latinxs were also more likely to believe that their standard of living was better than that of their parents (75% vs. 56%) and that their children would have a better standard of living than themselves (72% vs. 46%). Latinxs were more likely to believe in the core tenets of the American Dream even with concurrent beliefs that it is hard to achieve, let alone has yet been attained (Lopez et al., 2018). This line of research proposes the unique optimism tied to the American Dream as another potential protective factor and source of resilience implicated in the *Immigrant Paradox*.

Acculturative Stress as a Public Health Concern

A particular area that has recently warranted attention is how these patterns in lifestyle, cultural values, and personal attributes all act together to serve as physical and psychological sources of resilience--and by extension, health protection-- for the Latinx population in the US. However, despite these cultural strengths and resilience factors, immigrants undergo a bidimensional process of acculturation, whereby there is simultaneous pressure to adopt aspects of their new culture while also maintaining aspects of their culture of origin (Marin et al., 1996). This process of acculturation can lead to changes in identities, lifestyles, and behaviors that could be detrimental for health. For example, immigrants that once evidenced healthy habits upon arrival to the US begin to engage in substance abuse, adopt more sedentary lifestyles, and

consume more processed foods (Abraido-Lanza, Chao, & Flórez, 2005). Over time (i.e., with increased length of residence in the US) and in subsequent generations (i.e., offspring of first-generation immigrants), the observed Latinx health advantage is fundamentally transformed as these individual-level changes are met with macro-level systems of acculturation⁴. As immigrants in the US navigate acculturation processes, they face discrimination, systemic exclusion from complex systems (e.g., healthcare, education), language barriers, legal problems, and financial strain. All these systemic and structural challenges have been described as different facets of *acculturative stress* – the psychological and physical strain experienced by individuals when adapting to a new culture or society (Cervantes et al., 2016). Consequently, acculturative stress perpetuates persistent and pervasive health declines and becomes a key driver of health inequities in numerous sub-groups of the Latinx population (Gonzalez-Guarda et al., 2021).

The link between acculturative stress and a range of adverse mental and physical health outcomes in the Latinx population is well supported in the literature. In a systematic review examining relationships between acculturative stress and health consequences, acculturative stress was consistently associated with poor self-reported physical health, sleep outcomes, and a range of stress biomarkers (e.g., markers of systemic inflammation) in Latinx populations in the US (Gonzalez-Guarda et al., 2021). In a more recent study, acculturative stress demonstrated the largest effect on a syndemic factor (i.e., co-occurring epidemics often rooted in structural oppression) underlying substance abuse, intimate partner violence, HIV risk, and mental health conditions, all of which create complex and compounding health consequences in the Latinx immigrant population (Gonzalez-Guarda et al., 2023). The same study identified several

⁴ Here we refer to macro-level systems of acculturation as embodying all the larger societal structures and processes in the form of government policies, educational institutions, media, etc., that shape individual or group acculturation.

resilience determinants (including ethnic pride, individual resilience, and active coping among others) that interact with acculturative stress as a counter syndemic factor. These findings further underscore the interplay between the detriment of acculturative stress and the durability of resilience in Latinx communities amid these stressors. Taken together, these findings suggest that efforts to address the ramifications of acculturative stress will benefit from—if not necessitate—an examination of how to optimize resilience factors in this population.

Existing Interventions to Address Acculturative Stress

There have been several interventions designed to address acculturative stress. An acculturative stress evidence map of 35 studies on acculturative stress interventions found sample demographics to comprise primarily women, individuals from Mexico, and families or parents rather than adults and adolescents (Nagy et al., 2024). Provided the prominence of familism in the Latinx immigrant community, it is not surprising that a substantial number of existing acculturative stress interventions have been family-based prevention programs and parent training programs, with family-related stress and parental stress as intervention targets. Interventions such as *Fortalezas Familiares* (Valdez et al., 2013), *Madres a Madres* (Williamson et al., 2014), and *¡Unidos Se Puede!* (Cox et al., 2017) exemplify a shared emphasis on addressing facets of acculturative stress through the scope of familial functioning.

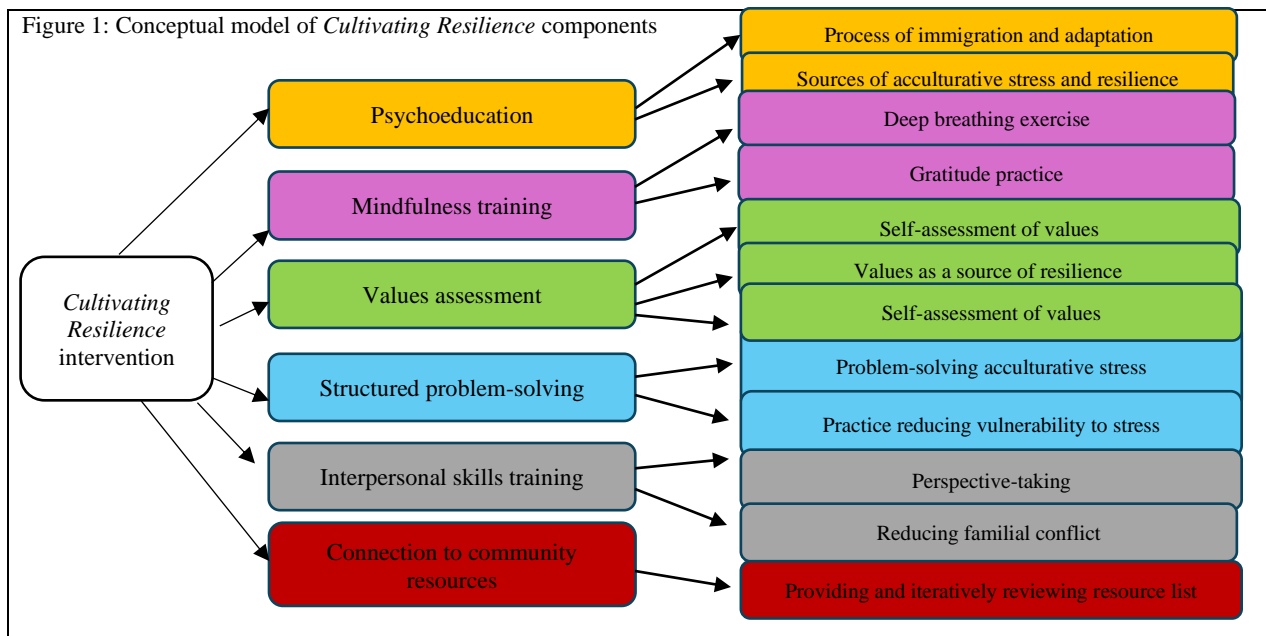
Moreover, the acculturative stress evidence map led by Nagy and colleagues (2024) highlights certain intervention design limitations. Specifically, many of these studies were not randomized controlled trials (RCTs), did not have a control group (i.e., utilized single-arm designs), and roughly half were self-identified pilot or feasibility studies without a clear focus on efficacy testing or wide-scale dissemination and implementation. A small minority of studies used formal measures of acculturation and less than half reported participants' baseline

acculturative stress. Further, these interventions were not integrated into healthcare settings. Consequently, despite the increasing body of research and interventions aimed at addressing acculturative stress, efforts have proved to be limited in their scope (i.e., not adequately targeting all aspects of acculturative stress) and reach (i.e., challenges in wide-scale dissemination), and thus are not making a significant and sustained impact on the health of Latinx populations.

A Novel, Acculturative Stress Focused Intervention: *Cultivating Resilience*

To address the need for interventions that will alleviate acculturative stress among Latinx adults, an eight-session psychosocial intervention⁵ named *Cultivating Resilience* (*Cultivando Fortaleza* in Spanish) was developed by our team. The intervention incorporates didactic, discussion, and experiential activities (e.g., skills-building exercises) relevant to six primary intervention components (i.e., psychoeducation about stress and resilience, mindfulness training, values assessment, structured problem-solving, interpersonal skills training, and connection to community resources). The conceptual model of the intervention's components and corresponding sample activities are illustrated in Figure 1.

⁵ Herein, we use the term “intervention” and “workshop” interchangeably in reference to *Cultivating Resilience*. The term workshop is used when we deliver *Cultivating Resilience* because this was the term that was selected by community partners.



Session activities are structured so that participants can gain exposure and engagement with these different skills, thereby facilitating navigation of the various stressors in their lives. In the context of a pilot RCT, the intervention was tested against a waitlist control in both in-person and virtual formats and delivered across five community sites (i.e., a Catholic church, a federally qualified health center, community health center, school, and a virtual community group) with $N=57$ adults in Milwaukee, Wisconsin identifying as Latinx or Hispanic. For the pilot RCT, the intervention was facilitated in Spanish by two bilingual, bicultural psychologists. Throughout the intervention, facilitators presented participants with session-specific homework for in-between sessions that allowed them to practice the skills emphasized that given week. This intervention, aiming to strengthen resilience factors as a buffer against acculturative stress and poor health outcomes, carries the paramount goal of wide-scale dissemination and implementation. To do so, it is important to closely examine implementation outcomes that can indicate--and predict--the capacity of the intervention to have its desired impact on a larger scale, beyond the scope of the RCT.

Importance of Evaluating Implementation Outcomes: Designing for Implementation

Early Evaluation of Implementation Outcomes Aims to Prevent Implementation Gaps

The traditional trajectory of research to practice operates on the assumption that implementation and dissemination are to be considered in a linear fashion, following rigorous evaluation of efficacy and effectiveness, which often results in implementation gaps or “interventions that are developed without early consideration of whether they can be broadly delivered, interventions that do not meet the needs of individuals excluded from the original efficacy or effectiveness trials, and the emergence of interventions that do not fit settings in which they could reach the target populations” (Chambers et al., 2016). Moreover, this trajectory is at odds with the demands of the mental health crisis (Garcini et al., 2022) which necessitates the development of interventions that can be widely disseminated, accessible, and suitable for underserved communities (including Latinx communities in the US) as soon as possible. There is therefore a simultaneous need to develop effective mental health interventions and to prioritize implementation for impact in the community during the intervention development phase.

Growing recommendations to address this need point to theory and practice in “designing for implementation.” This overarching principle has inspired specific models and competencies within the dissemination and implementation field such as *Designing for Dissemination and Sustainability* (Kwan et al., 2022). Designing for dissemination (i.e., proactively ensuring the compatibility between an intervention and its receiving settings and populations) and designing for sustainability (i.e., actively designing an intervention with an anticipatory focus concerned with the facilitators and barriers of its sustainment over time) influences every step of the decision-making and planning processes to ultimately promote the diffusion of evidence-based practices in targeted populations. *Designing for Dissemination and Sustainability* also points to

the dynamic nature of intervention design, highlighting the value of “iterative evaluation” to meet these competencies. Specifically, Kwan and colleagues (2022) propose that the intervention design process sees iterative evaluation of outcomes from the outset, including perceived acceptability, appropriateness, feasibility, implementability, sustainability, usability, usefulness, and user satisfaction.

Many of these outcomes are consistent with those outlined in the landmark *Implementation Outcomes Framework* (Proctor et al., 2011), which recognizes eight distinct implementation outcomes including acceptability (i.e., perceived agreeableness and satisfaction of the intervention); adoption (i.e., uptake of the intervention into practice); appropriateness (i.e., the intervention’s perceived suitability or fit for its intended setting, population, or problem); feasibility (i.e., the extent to which the intervention can be successfully used in its intended setting or population); fidelity (i.e., the degree to which the intervention’s implementation adhered to protocol or the manual); implementation cost (i.e., the cost of implementing the intervention); penetration (i.e., the integration of the intervention into its intended settings); and sustainability (i.e., the extent to which the intervention is maintained in its intended settings over time). These outcomes serve as measurable indicators of implementation success, and conversely, implementation gaps.

This pioneering work has observed a host of subsequent endeavors by implementation scholars to conceptualize and organize implementation outcomes. A review led by Proctor and colleagues (2023) aimed to investigate significant developments and discourse about these implementation outcomes in the decade since the conception of their original taxonomy. Among other notable findings, they observed several efforts made by research teams to conceptually divide implementation outcomes into meaningful categories. For example, Lyon and colleagues

(2019) suggest a conceptual distinction between “perceptual implementation outcomes” (i.e., acceptability, appropriateness, and feasibility) and “behavioral implementation outcomes” (i.e., adoption, fidelity, and penetration). The *Consolidated Framework for Implementation Research Addendum* (Damschroder et al., 2022) distinguishes between “anticipated implementation outcomes” (i.e., adoptability, implementability, and sustainability) that have not yet occurred and serve as indicators of future implementation success or failure; “actual implementation outcomes” (i.e., adoption, implementation, and sustainment) that have already occurred and serve as indicators of current or past implementation success or failure; and “antecedent assessments” (i.e., acceptability, appropriateness, and feasibility) that are not conceptualized as implementation outcomes but rather predict both anticipated and actual implementation outcomes. In addition to these findings on different conceptual applications, the review also sheds light on how implementation outcomes may have phase-specific relevance. Across studies, acceptability, appropriateness, feasibility, and adoption were predominantly evaluated during the early implementation stages whereas cost, fidelity, penetration, and sustainability tended to occupy later implementation stages.

Proctor and colleagues (2023) advocate for continuing the momentum documented in this scoping review by exploring how implementation outcomes themselves interact to advance health equity. They even suggest a model whereby equity is the function of service acceptability, appropriateness, and feasibility outcomes “summed together.” Thus, where implementation outcomes are optimized, as is health equity. This seemingly abstract and theoretical “equation” holds concrete significance; failing to design with implementation in mind can lead to services and interventions that are not acceptable, appropriate, or feasible for the community. The dissemination of interventions that do not meet the unique needs of populations can sustain the

research-to-practice gap that disproportionately harms vulnerable communities, thus exacerbating health and healthcare inequities (Baumann & Cabassa 2020; Weiner et al., 2023). This sentiment echoes similar calls to action from researchers to better integrate the health equity and implementation science fields (Woodward et al., 2021). Therefore, despite the literature evidencing heterogeneous operationalizations and conceptualizations of implementation outcomes, there is a unified message: Implementation outcome evaluation, intrinsic to designing for implementation, minimizes the risk of implementation gaps and strives to uphold health equity principles.

Designing for Implementation Benefits from Participatory Research

Designing for implementation often works in tandem with community-engaged research methods that seek to develop interventions “*with, for, and in the community*” (Baumann & Cabassa 2020). Specific participatory approaches, like community-based participatory research (CBPR)⁶, are recognized as powerful vehicles for improving dissemination and implementation research. Just as implementation outcomes ought to be at the forefront of the intervention development process, so do the voices of community collaborators⁷ whose expertise can propel and improve each stage of the implementation process. Assessing community wisdom from the outset helps to diminish the research-to-practice gap by capturing lay knowledge and expertise that has traditionally been delegitimized and disempowered at the expense of traditional scientific models and knowledge (Fleming et al., 2023). Approaches like CBPR can therefore increase the cultural appropriateness of an intervention, which can in turn influence other implementation outcomes, like its subsequent adoption and sustainability (Minkler et al., 2018).

⁶ “The systematic investigation, with the participation of those affected by the issue being studied, for the purposes of education and taking action or affecting change” (Green et al., 1994)

⁷ Herein, we will use terminology such as “community collaborators” to replace the word “stakeholders” which is being increasingly recognized as an offensive term rooted in colonialism.

Weiner and colleagues (2023) emphasize the significance of iterative consultations with community collaborators who can help determine any incongruencies between an intervention and the intended population or setting. These collaborations between researchers and the community are grounded in power-sharing principles, whereby community members are provided with all the information and materials relevant to the intervention in order to steer the research team's periodic adaptation efforts. Together, designing for implementation with participatory approaches avoid the pitfalls of "one-size-fits-all" interventions that often overlook unique community contexts and needs. Designing for implementation represents a paradigm shift away from often reactive, stagnant conclusions that communities are fundamentally "hard to reach," towards proactively reaching these very communities to make interventions and their implementation work for them. In this way, community-level expertise can be leveraged to identify what truly works, how, and under what conditions.

Importance of Evaluating Implementation Outcomes: Elucidating Core and Adaptable Components

Implementation outcomes are considered distinct from clinical treatment outcomes (Proctor et al., 2011); however, implementation outcomes are appreciated as key intermediate targets in the pursuit of achieving clinical outcomes/change (Weiner et al., 2023). As such, the significance of evaluating implementation outcomes is manifold; it ensures that an intervention is acceptable, appropriate, and feasible (among other implementation targets) and can in turn, optimize the intervention's effectiveness by making sure the intervention "works" (i.e., produced its intended treatment targets). In this respect, tracking implementation outcomes is a pursuit that can help elucidate, or shed light on, what is "core" to an intervention and what is "adaptable." Core components are considered the "active ingredients" underlying an intervention or

program's theory of change, "which proposes the mechanisms by which an intervention or program works," translating into positive "...proximal outcomes that address the identified needs and that increases the likelihood that longer-term outcomes will be achieved" (Blase et al., 2013). Adaptable components, in contrast, are considered the "modifiable aspects" of an intervention that can be tailored or refined without interfering with its core functions. To appreciate how implementation outcomes can have key implications in understanding core and adaptable components, it is first necessary to explore existing approaches research teams have adopted to determine core components of their programs.

Approaches to Understanding Core Components of Psychosocial Interventions

Despite the essential function of examining core components, the literature highlights a gap in programs and/or interventions that describe their core components with satisfactory detail on dosage, strength, and adherence conducive to those positive outcomes and an even greater absence of guidance in the identification of core components specific to acculturative stress interventions. Existing psychosocial interventions have the tendency to be lengthy and complex (Sutcliffe et al., 2015) with a limited focus on identifying their key ingredients, which may obscure these central elements, increase participant burden and barriers to engagement, and jeopardize the ability to make necessary contextual adaptations. Conversely, distilling an intervention to its central elements enhances clinical effectiveness, cost-effectiveness, adaptation, and is aligned with professional ethics related to providing appropriate and beneficial interventions (Mooss et al., 2015; National Academies of Sciences, 2019).

Multiple approaches have sought to evaluate the core components of interventions. Traditionally, this pursuit has lived within the space of rigorous mechanistic studies seeking to

understand the “internal logic”⁸ of interventions. For example, researchers have carried out component analysis strategies (also referred to as “dismantling treatment strategies”) within the field of psychotherapy in the identification of core elements. This approach seeks to understand the effectiveness of different components by systematically breaking down (i.e., dismantling) a complex intervention or treatment into individual components and examining their impact on outcomes (i.e., testing a full treatment package against a “dismantled condition” with a removed hypothesized core component). As a result, researchers can better identify which specific configuration of components is responsible for the treatment effectiveness, leading to a more nuanced understanding of the intervention’s core components. Consequently, this enables refinement of the intervention manual to underscore these active ingredients (Hunsley et al., 1999). Historically, the component analysis approach has been observed within the study of cognitive-behavioral therapy (CBT) by systematically testing the individual components (e.g., behavioral activation and cognitive restructuring) of the therapy to compare with the full treatment condition and subsequently track any differences in treatment outcomes (i.e., clinical improvements in depression; Hunsley et al., 1999). This method, which is increasing in both rigor and specificity, is reflected in newer studies; for example, researchers have attempted to understand the active ingredients in mindfulness-based programs by testing variations of its individual components (e.g., acceptance and open monitoring). This has enabled researchers to test, for example, monitor only conditions against monitor *and* acceptance conditions (i.e., the full intervention package) to elucidate the active ingredients (Stein et al., 2020).

⁸ “Internal logic” [of an intervention] refers to “the explanation of the relationships among intervention activities, behavioral determinants, and the intended outcome(s) of the intervention” (McKleroy et al., 2006).

Other approaches to understand core components have been based more on perceptions of the given intervention rather than on its specific mechanisms. For example, the literature describes various types of Delphi methods, which involve iterative processes or “rounds” of gaining consensus from expert panelists (Barret et al., 2020; Shang 2023). Research teams have successfully leveraged Delphi methods as a robust, consensus-building approach in the evaluation of core components (O’Rourke et al., 2018; Felver et al., 2022). To illustrate, to evaluate the core components of “nurse-nurse handoff”⁹ procedures for standardization of practice, O’Rourke and colleagues (2018) engaged in a Delphi process of three rounds. Expert panelists, comprising clinical nurse leaders, nursing faculty, and other experts/ researchers in the field, were asked to quantitatively rate the importance and relevance of four components (i.e., Illness Severity, Patient Summary, Action List, and Synthesis by Receiver) and to provide open-ended feedback via an iterative questionnaire. Items not meeting 80 percent consensus at the end of a round were modified by researchers and incorporated into the subsequent round until consensus on all items was reached. Through this process, panelist feedback resulted in changes to and omissions of certain components, yielding the finalized conceptualization of nurse-nurse handoff core components (i.e., Patient summary, Action plan, and Nurse–Nurse Synthesis; O’Rourke et al., 2018). Research has also adopted Delphi methods to identify the core elements of mindfulness-based programs, offering a methodological contrast to the component analysis approach within this research area. For example, expert scientists and instructors in the field of mindfulness participated on a Delphi panel that endorsed a set of components (i.e., self-awareness, non-judging, focused attention, somatic awareness, etc.) as essential for mindfulness-

⁹ “Nurse-nurse handoff” refers to the transitional period whereby a nurse transfers pertinent patient information and overall patient responsibility to another nurse; this process is considered fundamental for effective communication and positive patient outcomes despite a lack of standardization and widespread adoption of the practice (O’Rourke et al., 2018).

based programs in youth populations (Felver et al., 2022). Notably, a different consensus benchmark (75 percent) was applied in this study, showcasing the heterogeneity in “consensus” present in the Delphi method literature. Indeed, many have noted that “consensus,” as the primary target of this approach, is often inconsistently and ambiguously applied across studies. Further, the consensus may be a result of certain biases that gravitate towards the majority view throughout subsequent rounds (Barret et al., 2020).

These existing approaches in the determination of core components are limited in important ways. Across methodologies, the value of expert participation often comes at the detriment of excluding community members and end-users¹⁰ (Ismail et al., 2020). Exclusive criteria for who qualifies as an expert, such as educational attainment and authorship in peer-reviewed manuscripts, may silence the broader spectrum of voices in the community and in effect restrict appropriate cultural representation in research (Shang 2023; Yousuf, 2007). Moreover, these methods have the tendency to be time- and resource-intensive, especially in the context of complex, multicomponent interventions where multiple rounds or phases of testing may be required (Riden et al., 2022; Yousuf, 2007).

Examining Implementation Outcomes as an Approach to Assess Core Components and Promote Functional Adaptations

While implementation outcomes are not typically believed to pinpoint the causal mechanisms of Evidence-Based Interventions (EBI), they have been leveraged to assess core components and guide subsequent adaptation processes. In fact, the current field of implementation science underscores the need to identify core and adaptable components to understand not only the mechanisms of change but also to guide successful adaptation efforts

¹⁰ “End users” refer to individuals or groups who are the intended recipients of a given product, system, or intervention.

(Blase et al., 2013). When pursuing context-appropriate modifications, adaptations preserve the identified core components to not interfere with the integrity of the intervention's causal model or underlying theory. Consequently, functional adaptations that refine an intervention to be responsive to contextual needs while retaining its core components hold the potential for increasing the spread, uptake, scaling up, and sustainability of an intervention. Specifically, the literature makes a distinction between "function" and "form," whereby researchers and interventionists tailor or change the form (i.e., the place, language, and metaphors used) of a program while maintaining the underlying function (i.e., the mechanisms driving change or effectiveness; Blase et al., 2013).

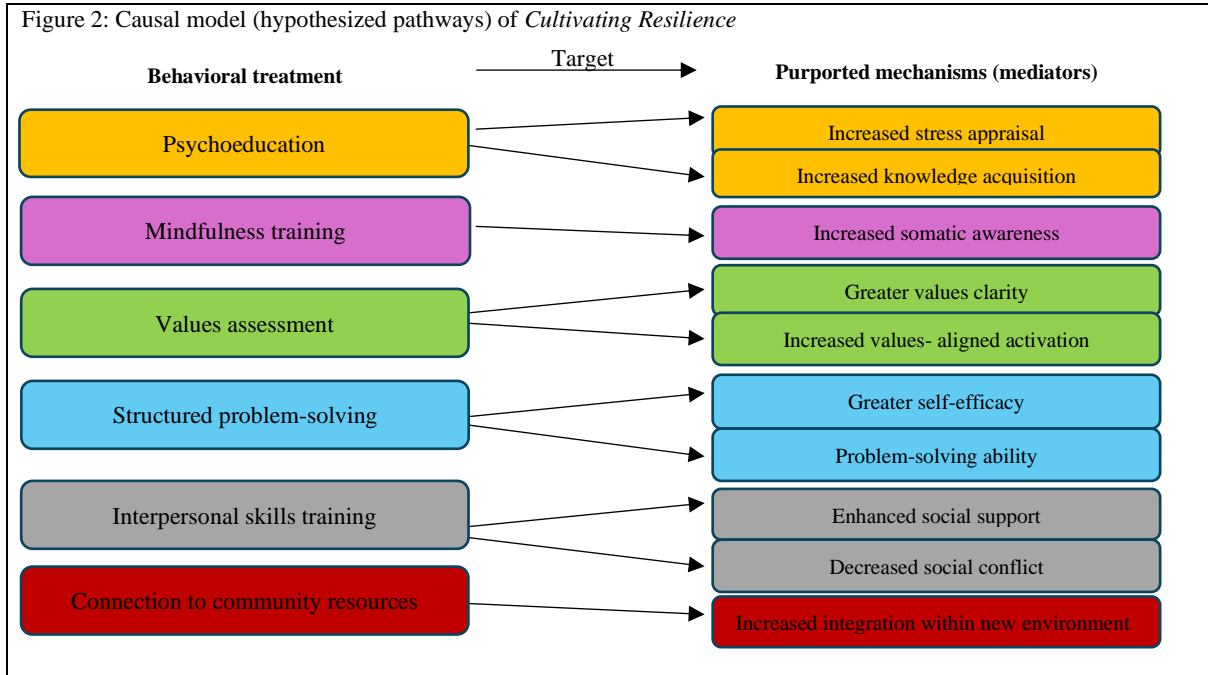
This is reflected in various adaptations of family and parent-based interventions transported from predominantly non-Hispanic White populations to minoritized populations. For example, *Nuestras Familias*, a culturally adapted version of Parent Management Training (PMT), preserved core PMT components (e.g., skills building and problem-solving) while concurrently making adaptations (informed by the literature on how acculturative stress impacts Latinx families) to improve the cultural appropriateness of materials for a predominantly Mexican-origin population (e.g., adding modules that focus on bridging cultures, Latinx roots within the family unit, etc.; Martinez & Eddy, 2005). Similarly, *Guiando a Niños Activos*, a culturally adapted version of Parent-Child Interaction Therapy (PCIT), evidenced a similar adaptation process that engaged a focus group method (i.e., listening sessions with parents and therapists) to determine modifications that were more responsive to cultural parenting types and preferences for Mexican families (McCabe et al., 2005). Thus, the core components remained throughout the adaptation process but certain implementation outcomes, including the acceptability and appropriateness of the program, were evaluated and optimized (Zayas et al.,

2009). The importance of these types of cultural adaptation practices is in line with the literature demonstrating, that “program changes addressing cultural context, language, and literacy are the most common adaptations made by sites, followed by modifications related to the program duration or pace” (Stirman et al., 2013). However, as described by the Framework for Reporting Adaptations and Modifications-Expanded (FRAME; Stirman et al., 2019), the nature of modifications that can be made to interventions is vast. Content level modifications include tailoring/tweaking, but they also embody adding elements, removing elements, condensing (pacing/timing), and reordering intervention content (e.g., modules), among others. Concurrently, modifications at the contextual level may be made to format, setting, personnel, and population elements. Therefore, one can begin to observe the interrelated nature of implementation outcomes, core components, and community-engaged adaptations, whereby research teams can seek feedback about certain implementation outcomes to evaluate core components and make necessary adaptations accordingly.

Development of the Cultivating Resilience “Core” Package

The development of the *Cultivating Resilience* intervention occurred through both a *top-down approach* of identifying CBT components with a robust evidence base in the scientific literature that could be useful in addressing acculturative stress, and a *bottom-up approach* of iteratively consulting with community and academic partners over two years to integrate their expertise into the content of the intervention. This process yielded the six evidence-based CBT-informed components interspersed throughout the eight *Cultivating Resilience* sessions. Each of these components comprises knowledge or skills (i.e., the “behavioral treatment”) that target purported mechanisms of change (i.e., the “mediators”). Together, they comprise the

hypothesized core package of the *Cultivating Resilience* intervention. The causal model illustrating the hypothesized pathways of the intervention can be observed in Figure 2.



Aims of the Present Study

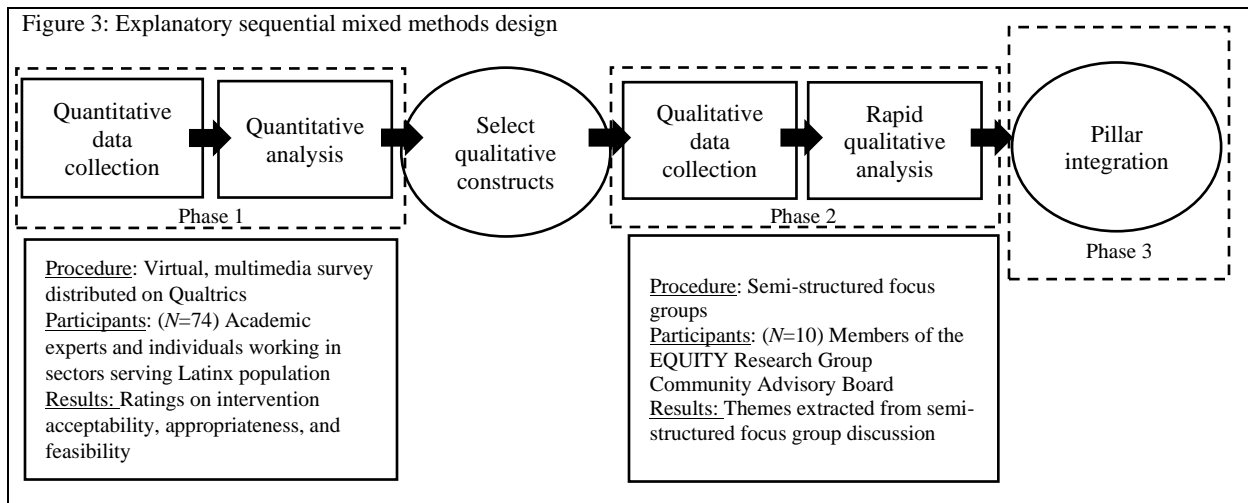
In the context of the pilot RCT of *Cultivating Resilience* ($N=57$) our research team has received feedback on intervention acceptability and feasibility derived from exit interviews with participants as well as post-session surveys. Preliminary findings on acceptability and feasibility demonstrate that participants have enjoyed newfound knowledge and skills from the intervention, in addition to diminished symptoms of depression, anxiety, and acculturative stress. However, we are currently interested in expanding the scope of feedback about the intervention’s hypothesized core components (i.e., content) and implementation factors (i.e., delivery) with a particular focus on evaluating and optimizing the intervention’s acceptability, appropriateness, and feasibility for Latinx immigrants. To this end, the present mixed methods study seeks to evaluate the *Cultivating Resilience* intervention by compiling community expertise and

leveraging existing theoretical implementation frameworks (Proctor et al., 2011; Weiner et al., 2017). Thus, this study hopes to build on the growing literature that a) demonstrates the value of community-engaged methods in evaluating implementation outcomes and that b) describes more perceptual directions for understanding core and adaptable components that can complement a broader configuration of existing methods. The study is detailed in three aims, with three corresponding phases. In Phase 1, we aim to report quantitatively on the intervention's perceived acceptability, appropriateness and feasibility elicited through the distribution of a multimedia survey (i.e., comprising text, graphic, and video description of intervention components) completed by $N=74$ individuals identifying as academic experts in the areas of acculturative stress, implementation science, and/or as having lived or professional experience working with Latinx communities. In Phase 2, we present qualitative themes extracted from the survey's open-ended feedback and two subsequent focus groups with members of our research team's Community Advisory Board ($N=10$). In Phase 3, we aim to integrate our quantitative and qualitative datasets to extract pillar-building themes per component. Together, these aims will generate comprehensive knowledge about the intervention foci, which can guide the refinement, optimization, and adaptation of the intervention. These efforts will further advance the goal of informing subsequent implementation and dissemination efforts across culturally diverse settings, communities, and with different interventionists.

Methods and Materials

Design

Herein, we integrate data from quantitative (i.e., survey ratings and proportions) and qualitative (i.e., themes from focus groups and open-ended survey feedback) data that was collected using an explanatory sequential mixed methods design (depicted in Figure 3). In line with this selected design, ongoing quantitative data collection informed the qualitative focus of two focus groups. This specific design facilitated a unique cyclic process of gaining qualitative feedback that ultimately functioned to contextualize and help explain our quantitative findings. Quantitative and qualitative datasets were analyzed separately and then integrated to extract pillar-building themes. Study procedures were approved by the University of Wisconsin-Milwaukee Institutional Review Board.



Procedures for Data Collection

Survey Recruitment Activities

Recruitment occurred over a five-month time frame from April through August of 2024 in which $N=240$ individuals were invited to take our virtual survey. Recruitment activities were documented in an Excel spreadsheet that tracked contact information of individuals we invited to complete the survey (including names and their respective email addresses). We intended to recruit individuals with a vast array of affiliations (e.g., implementation scientists, community health workers, consultants, therapists, psychologists, etc.). However, prospective participants were classified into one of two groups in our recruitment spreadsheet: “researcher/academic” or “professional working in sector serving Latinx/Hispanic communities.” This primarily served an organizational function; we understood that individuals might identify with both classifications and that the survey’s demographic questions would further delineate nuances in participant affiliation. Individuals were also classified and contacted in batches (i.e., “waves”). The number of participants contacted in each batch was guided by the availability of remaining gift cards we had to compensate participants. Individuals were invited to take the survey via an email that addressed them by name, gave a brief overview of the project, and provided a link for them to virtually complete the survey through the Qualtrics database. We sent follow-up emails one week following the first contact emails, providing a gentle reminder to complete the survey if they had not already and were interested in doing so. There were minimal deviations to this protocol, including delayed or no follow-up. Specifically, at the beginning of our recruitment efforts, we did not intend to have a follow-up procedure; however, after observing a low response rate in our first recruitment batch, we decided follow-up communication may be necessary. This resulted in the first batch of recruitment contacts receiving delayed follow-up (i.e., they were contacted one

month following initial contact, after our team decided to institute the follow-up procedure). Other instances of delayed follow-up included if prospective participants explicitly asked to be contacted at a specified later date. We did not send follow-up communication to contacts who explicitly declined participation after our first contact email.

Our recruitment process relied heavily on convenience sampling strategies, drawing on contacts from pre-existing academic and community relationships who we knew to work with the Latinx/ Hispanic community and/or have topic expertise in acculturative stress or implementation science. We also welcomed word-of-mouth referrals (e.g., we welcomed participants who completed the survey to offer additional contacts from their respective organizations/networks). However, as we intended to recruit nationally to promote diversity in geographic regions, professional sectors, and affiliations, we diversified our recruitment strategies. For example, we identified recruitment contacts through literature searches (using keywords “implementation science,” “Latinx studies,” “acculturative stress,” “cultural adaptations of interventions,” etc.). We further identified contacts by browsing staff directories on the websites of community-based organizations and the directories from several relevant conferences (i.e., hosted by the Midwestern Psychological Association, Society for Prevention Research, and Society for Implementation Research Collaboration). Our recruitment efforts also involved several iterative rounds of targeted recruitment strategies. As an increasing number of individuals completed the survey, we conducted preliminary rapid analyses of participant demographics to identify any emerging patterns. We observed, for example, that the demographic composition of our sample was skewed in favor of researchers/academics. Therefore, we explored more community health organizations to find additional contacts of non-academics to recruit. We also observed that the demographic composition of our sample was

heavily skewed in favor of participants identifying as women. We sent multiple batches to male contacts identified through targeted literature, organization, and conference directory searches.

Survey Battery and Measures

Eligibility and Consent

Prior to enrolling in the survey, participants completed eligibility screening virtually on the first page of the survey (upon opening the survey link). Participants were prompted to endorse the eligibility criteria for which they met: *1) adult; 2) speak English; 3) lived and/or professional experience in working with Latinx immigrants or refugees, acculturative stress, or implementation science*. Individuals who endorsed all three of these inclusion criteria were subsequently guided to the consenting procedure; those who did not meet all three criteria were ineligible to participate and prompted to the end of the survey.

The consenting procedure was also administered virtually following the eligibility screening. Participants read a self-guided consent form within the survey window (in addition to a downloadable form for their own personal records) outlining the scope of the study, risks and safeguards, benefits, information pertaining to compensation, and study contacts. Prospective participants enrolled in the survey if they endorsed “*Agree*” to the following statement: *“I have read the above information. I voluntarily agree to participate,”* and provided their electronic signature of consent. Individuals who did not agree to this statement or did not provide their electronic signature of consent were guided to the end of the survey.

Demographic Questionnaire

Within the survey, a demographic questionnaire (see Appendix A for specific questions) characterized survey participants based on age, professional affiliation, affiliation with Latinx

communities, geographic region, gender identity, ethnicity, race, and level of education. While participants' identities could be considered indirectly identifiable due to this combination of demographic data collected, the survey did not ask for direct identifiers (i.e., name).

Multimedia Videos

As part of our team's efforts to cultivate culturally sensitive tools and strategies to engage diverse populations, our research team used the graphic design platform Canva to develop multimedia videos (see Appendix B for sample screenshots of videos) to embed within the survey that provide a visual and auditory representation of each component of the *Cultivating Resilience* intervention. This video creation process relied on collaborative, iterative design meetings with the research team to prioritize an accurate and appropriate portrayal of intervention concepts. Survey participants were prompted to view each component video prior to providing any ratings or giving any qualitative feedback about the component.

Implementation Outcome Measures

The principal focus of the survey was to acquire feedback from participants about the *Cultivating Resilience* intervention grounded in three implementation outcomes of interest to our team (i.e., acceptability, appropriateness, and feasibility). As such, questions were developed corresponding to each of these constructs (see Appendix C for complete survey questions). Specifically, survey participants were asked to provide ratings about each component's acceptability and appropriateness on a scale from 1 (*Strongly Disagree*) to 5 (*Strongly Agree*). Guided by these considerations, participants then had the opportunity to elaborate on any additional feedback, concerns, or comments they had related to each component through an open-ended feedback option. After answering acceptability and appropriateness questions for each component, participants were asked a set of questions about the intervention's feasibility,

which focused on several considerations for how the intervention can be successfully delivered or rolled out (i.e., considerations of delivery methods, formats, dose, implementations strategies, facilitators, and settings).

These questions were formulated after consulting the existing implementation outcome taxonomies and measures. Specifically, they are anchored in the conceptual definitions of acceptability, appropriateness, and feasibility advanced by Proctor and colleagues (2011) and *The Acceptability Implementation Measure (AIM)*, *Intervention Appropriateness Measure (IAM)* and *Feasibility of Intervention Measure (FIM)* developed by Weiner and colleagues (2017); this triad of implementation outcome measures was created as a set of brief, face-valid survey measures of community and academic collaborators' perceptions of acceptability, appropriateness, and feasibility (Weiner et al., 2022). They are considered guiding frameworks that help intervention or program developers determine EBI contextual (i.e., population, setting) fit and likelihood of successful implementation. Our team preserved the main intent of each of these measures but modified the language of the questions to reflect the nuance of cultural dimensions we sought to assess. For example, *IAM* items addressing general EBI fit, suitability, applicability, and match were modified into questions that specifically address the cultural fit, suitability, applicability, and match of *Cultivating Resilience* components with/to Latinx values and experiences of acculturative stress. In the same way, *FIM* items that broadly assess whether an EBI is implementable, possible, doable, and easy to use formed the basis of survey questions evaluating the implementability of specific delivery factors related to *Cultivating Resilience*.

Compensation

At the end of the survey, participants were given the choice to be compensated with a twenty dollar (\$20) electronic gift card, in which case they were prompted to a compensation

survey through a separate Qualtrics link to provide their email address. Our research team routinely monitored responses to this compensation survey in order to promptly contact participants via email with their respective redemption code (and instructions) for activating their gift card.

Focus Group Procedures

A series of two focus groups were held with Latinxs currently serving on the EQUITY Research Group's Community Advisory Board ($N=10$). The focus groups were scheduled during the lab's quarterly reunions with board members, located on the University of Wisconsin-Milwaukee campus. Each focus group lasted approximately one hour and a half and was recorded (consistent with the lab's standard procedural practices for recording Community Advisory Board meetings) to facilitate subsequent qualitative analysis. The focus groups were facilitated in Spanish by the Principal Investigator of the EQUITY Research Group while three graduate students and a research coordinator took notes.

Focus Group Instruments

Semi-Structured Interview Guides

Rapid preliminary analyses of the survey's quantitative ratings and qualitative open-ended feedback informed the thematic scope of the semi-structured interview guide used in each focus group. These preliminary analyses primarily resulted in questions grounded in the cultural appropriateness of intervention components. For the first focus group, we developed questions (See Appendix D and E) relevant to the mindfulness training, values assessment, and structured problem-solving components, in addition to a question inquiring more broadly about potential adaptations of *Cultivating Resilience*. The second focus group was dedicated to questions (See Appendix F and G) pertaining to interpersonal skills training, psychoeducation, and connection

to community resources components. In addition to the interview guides, our team distributed complementary handouts (i.e., guides and exercises) used in the *Cultivating Resilience* intervention; this allowed focus group participants to observe how the components are presented in the intervention, thus facilitating a more nuanced understanding of the components to elicit informed feedback.

Data Analysis

Quantitative Data Analysis

After the data collection period was complete, survey data was exported from the Qualtrics database and imported to the Statistical Package for the Social Sciences (SPSS) software. After importing the dataset into SPSS, several data cleaning steps were performed, including deleting unnecessary variables (e.g., IP address, start date, etc.) and scanning the dataset to ensure the consistency and accuracy of value labels, variable names, and variable types (e.g., string, numeric, etc.). Quantitative data analysis primarily consisted of descriptive (i.e., summary) statistics to calculate average and median ratings as well as response frequencies (i.e., via generated frequency tables) that characterize participants' perceptions of *Cultivating Resilience* components and delivery. With respect to component ratings, we found it useful to analyze (and report) not only averages but also medians, as the latter can be a more accurate indicator of central tendency considering skewed datasets.

Qualitative Data Analysis

Qualitative data analysis involved synthesizing data from numerous sources, including audio recordings of the focus groups, notes taken by research team members during the focus group sessions, and the survey's open-ended feedback responses. The qualitative data was organized into a codebook (see Appendix H) structured by the feedback pertaining to each

domain (component) of the intervention and the corresponding questions posed in the focus groups. Exemplary quotes (from the focus groups and survey) helped determine codes that were then grouped into broader thematic categories to support subsequent pillar-building integration.

Mixed Methods Data Integration

The quantitative and qualitative datasets were analyzed independently and then subsequently integrated at the level of analysis per component using a pillar-building approach (Johnson et al., 2017). First, we listed and categorized raw data from both the quantitative and qualitative analyses. For the quantitative analyses, this included listing average and median ratings per component, categorized by constructs of acceptability and appropriateness; for the qualitative analyses, this entailed listing exemplary quotes grouped into codes and categories. We then analyzed how quantitative and qualitative categories converged on pillar-building themes related to acceptability and appropriateness for each component. To view the generic model of this approach as described in the Johnson et al. (2017) seminal paper, see Appendix I. To see how we leveraged this model for the purpose of the current study (i.e., a joint display of our quantitative and qualitative findings), see Appendix J.

Our rationale for adopting a mixed methods approach was to provide a more comprehensive story of the intervention's perceived acceptability and appropriateness than either independent quantitative or qualitative analysis offers alone. Specifically, while quantitative analysis allowed us to quantify our constructs of interest, the mixed methods analysis enabled us to contextualize the quantitative data with qualitative, real-life experiences and insights. Moreover, this approach addressed concerns that quantitative ratings often yield concentrated responses, such as those skewed toward the "very important" dimension (Mowbray, 2003); thus,

by incorporating qualitative evaluation, this study avoids that limitation, creating opportunity for richer feedback about the intervention.

Reflexivity and Credibility

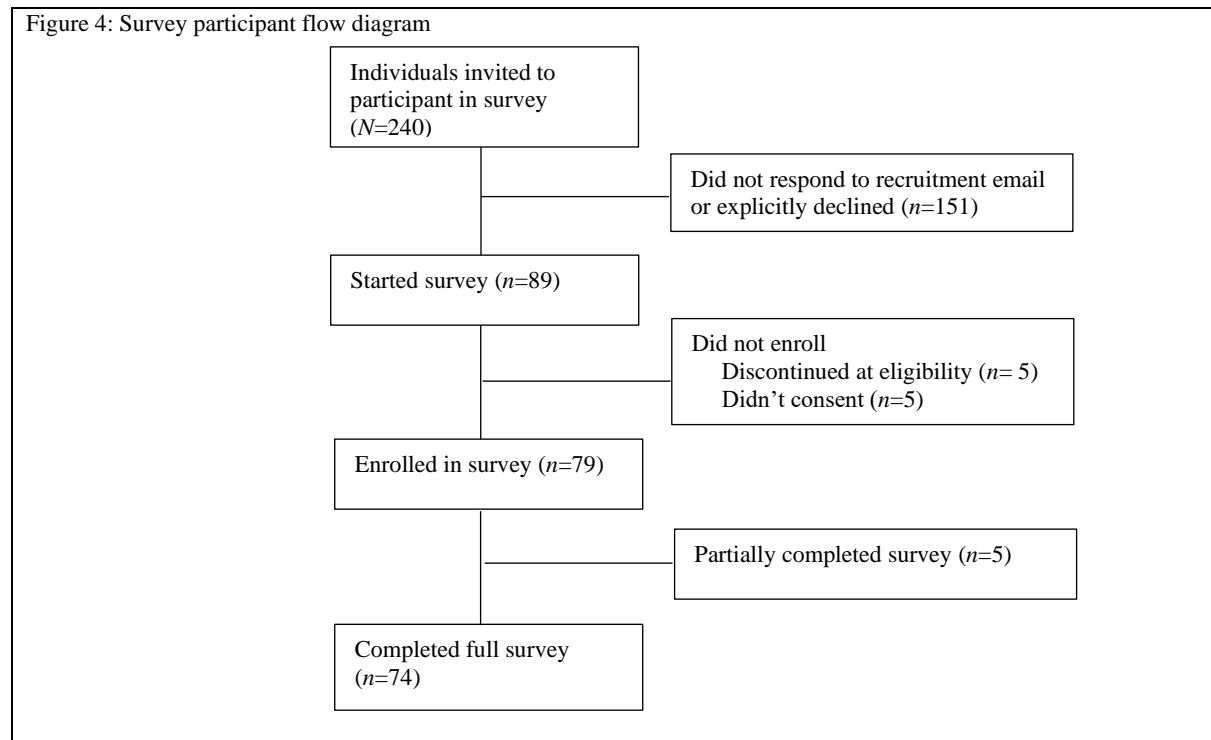
As a non-Hispanic Caucasian woman, it is important to acknowledge my positionality within study activities, specifically how inherent biases and blind spots were potentially present in the interpretation of data. Throughout the course of the study, it was a priority of mine to maximize exposure to and engagement with Latinx communities in the Milwaukee, Wisconsin area to counteract some of these blind spots and continue to learn and grow both personally and professionally. Within the scope of *Cultivating Resilience* study activities, this engagement included observing the intervention being delivered, going out in the community to help collect baseline and outcome data as a secondary assessor for the pilot RCT, and holding an ongoing role as part of the treatment development team. More broadly, I attend the quarterly meetings with our research group's Community Advisory Board, consult with team and community members who are Latinx, participate in community volunteering events, and continue to be involved in related projects with this population as a result of my engagement in the research group. The analysis of data for the present study (which included both translation and interpretation of qualitative feedback), occurred through collaborative - not individual - efforts involving members of the research team who do identify as second-generation Latinxs and who have lived experience. These members were instrumental in this project, taking detailed notes during focus groups (of raw qualitative feedback and interpretative commentary) and offering ongoing consultation and oversight.

Results

Characteristics of Participants

Survey Participants

Refer to Figure 4 for a participant flow diagram. Of the 240 individuals who received an invitation to participate in the survey, 89 opened the survey link. Another 151 either did not respond to our recruitment email (i.e., did not open the survey link) or explicitly declined participation in a response email (i.e., emailed our team citing different personal reasons for their inability to participate and declined any further follow-up communication), signifying that our team had approximately a 37% response rate. Of the 89 who opened the survey link, 5 did not complete eligibility and another 5 did not complete the following consenting procedure; therefore 79 enrolled in the survey. Of those who enrolled, 5 partially completed the survey (i.e., they did not finish the survey) and 74 completed the survey in its entirety.



See Table 1 for the demographic characteristics of survey participants. Of respondents, the mean age was 43.73 years. Regarding race, the majority identified as White (42.7%), or Multiracial/ Biracial/ Mixed Race (31.5%). However, some participants identified as Black or African American (7.9%), American Indian or Alaska Native (2.2%), Asian (2.2%), and Native Hawaiian or Other Pacific Islander (1.1%). Regarding ethnicity, more than half of the sample (71.8%) identified as Hispanic or Latino/a/e/x as opposed to not Hispanic or Latino/a/e/x (28.2%). Survey participants were predominantly from the South (35.9%) and Midwest (32.1%) regions of the United States, although our efforts to recruit nationally resulted in participants from the Western (16.7%) and Northeast (9%) regions, albeit in lesser numbers. Despite our research team's efforts to diminish the gender bias in our sample throughout recruitment, survey participants were overwhelmingly women (74.4%), followed by men (24.4%), and agender or nonbinary (1.3%). While this may reflect a degree of biased sampling (i.e., our team invited more women than men to complete the survey), it could also be an indicator of a reduced response rate among men. The majority of participants had doctorate degrees (60.3%); relatedly, many in our sample described their professional affiliation(s) as professors/researchers/academics and/ or scientists (37.29%). However, consistent with our intentions to recruit from a diverse range of academic, professional, and community backgrounds, participants were affiliated with a range of other professions including as clinicians/health care providers/administrators (22.03%) and as employees at community-based organizations/non-profit agencies (16.95%). Several also described themselves as community advocates/community organizers/community leaders/elected leaders (10.17%) and community health workers/peer specialists/lay providers (7.63%).

A rapid qualitative analysis of participants' responses to the question "*In what ways have you worked with the Latinx/Hispanic community?*" highlighted their rich professional and lived engagement across Latinx communities. A substantial number of participants described their work with Latinx populations as social workers, mental health providers, and clinicians in both in-patient and outpatient settings. Several also detailed their involvement in community-engaged research and social drivers of health programming, working alongside Latinx adolescents and families. Many of our survey participants had experience advocating, coordinating, and mobilizing at the community level for policy change. Some described specific initiatives they led within their respective communities, such as facilitating COVID-19 outreach, organizing vaccination events, and leading programs in nutrition and health. Our sample demonstrated content expertise across a vast range of fields, from mindfulness (as mindfulness curriculum educators) to law (as bilingual paralegals and leaders within Hispanic Lawyer Associations) to reproductive justice (as reproductive health care providers). Many survey participants also had experience working with Latinx populations through implementation science backgrounds, including working with communities to adapt mental health interventions/tools and researching chronic disease prevention and barriers to mental health service uptake in Latinx communities. A smaller portion of the sample described roles as ESL (English as a Second Language) instructors, interpreters, and philanthropists.

Table 1: Demographic characteristics of survey participants

Demographic Variables	Survey Participants		
	N	M(SD)	%
Age	---	43.73(11.05)	---
Race (multiple responses allowed)			
American Indian or Alaska Native	2	---	2.2
Asian	2		2.2
Black or African American	7		7.9
Multiracial, Biracial, Mixed Race	28		31.5
Native Hawaiian or Other Pacific Islander	1		1.1
White	38		42.7
Another Race not Listed	4		4.5
Prefer not to respond	2		2.2
Don't know	3		3.4
Ethnicity		---	
Hispanic or Latino/a/e/x	56		71.8
Not Hispanic or Latino/a/e/x	22		28.2
Region		---	
Northeast	7		9
South	28		35.9
Midwest	25		32.1
West	13		16.7
Prefer not to respond	3		3.8
Don't know	2		2.6
Gender		---	
Man	19		24.4
Woman	58		74.4
Agender or Non-Binary	1		1.3
Education		---	
High school degree (GED)	2		2.6
Some college	4		5.1
Associates degree or Trade school	4		5.1
Bachelor's degree	6		7.7
Master's degree	15		19.2
PhD/MD	47		60.3
Professional Affiliation (multiple responses allowed)			
Professor, researcher, academic, and/or scientist	44		37.29
Clinician, health care provider, administrator/leader	26		22.03
Trainee or student	1	---	0.85
Community health worker, promotor de salud, peer specialist, lay provider	9		7.63
Employee at a community-based organization, non-profit agency, 501(c)(3)	20		16.95
Community advocate, community organizer, community leader, elected leader	12		10.17
Independent community member (not affiliated with a particular organization)	4		3.39
Religious leader (e.g., priests, pastors, ministers, deacons, elders, nuns)	1		0.85
Other	1		0.85

Focus Group Participants

Characteristics of Community Advisory Participants who participated in the focus groups are described in aggregate to protect their privacy. Of the $N=10$ total Community Advisory Board members, $n=10$ and $n=8$ members participated in the first and second focus groups, respectively. The Community Advisory Board is comprised equally of men and women identifying as first- or second- generation Latinxs/Hispanics. For the majority of members, their preferred language is Spanish. Members come from diverse professional backgrounds as social workers, community health workers, professors, physicians, and business owners.

Perceived Acceptability and Appropriateness Across Components

Mindfulness Training

Quantitative Results

The component indicated high acceptability (i.e., “*aggregable and appealing*”; $M=4.27$, $SD=1.024$), further demonstrated by a median rating of 5.00 (strongly agree). Notably, two dimensions of appropriateness (i.e., “*acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics*” and “*adequately addresses the topic of acculturative stress*”) were rated lower ($M=3.59$, $SD=1.059$ and $M=3.88$, $SD=.944$ respectively). Each of these dimensions of appropriateness had a median rating of 4.00 (agree). The third dimension of appropriateness (i.e., “*holds the potential to have a positive health impact by reducing acculturative stress*”) was rated higher ($M= 4.40$, $SD=.822$), with a median rating of 5.00. See Table 2 below for the mindfulness training component’s full distribution of ratings, including frequency of responses.

Table 2: Mindfulness training ratings			
	M(SD); m(IQR)	N	%
Acceptability (<i>agreeable and appealing</i>)	4.27 (1.024); 5 (4-5)	--	--
(1) Strongly disagree	--	4	5.4
(2) Disagree		1	1.4
(3) Neither disagree nor agree		4	5.4
(4) Agree		27	36.5
(5) Strongly agree		38	51.4
Appropriateness (<i>respects Latinx values</i>)	3.59 (1.059); 4 (3-4)	--	--
(1) Strongly disagree	--	3	4.1
(2) Disagree		7	9.5
(3) Neither disagree nor agree		23	31.1
(4) Agree		25	33.8
(5) Strongly agree		16	21.6
Appropriateness (<i>adequately addresses acculturative stress</i>)	3.88 (.944); 4 (3-5)	--	--
(1) Strongly disagree	--	1	1.3
(2) Disagree		5	6.7
(3) Neither disagree nor agree		17	22.7
(4) Agree		31	41.3
(5) Strongly agree		21	28.0
Appropriateness (<i>has potential to have positive health impact by reducing acculturative stress</i>)	4.40 (.822); 5 (4-5)	--	--
(1) Strongly disagree	--	1	1.3
(2) Disagree		1	1.3
(3) Neither disagree nor agree		7	9.3
(4) Agree		24	32.0
(5) Strongly agree		42	56.0

Qualitative Results

Participants identified multiple aspects of mindfulness training that are favorable. They appreciated how mindfulness moves from awareness and knowledge acquisition to an actionable (i.e., concrete) skill individuals can use in their daily lives: “This topic is much better than [psychoeducation] because mindfulness practice is something that they [intervention participants] can take action on.” Relatedly, participants liked that the component is easily accessible: “I love that mindfulness, when taught well, is accessible and not something that requires a lot of money. This is an assumption of a lot of wellbeing strategies, that it’s expensive or too timely to incorporate.” Lastly, the subcomponent of gratitude was particularly regarded favorably: “I really like the emphasis on gratitude, I think this will be very appealing to the group.”

Participants also expressed important contextual factors that influence the cultural appropriateness of mindfulness training; perhaps the most salient factor was in reference to the vast heterogeneity in religious preferences and affiliations within Latinx populations. In particular, three clusters of perspectives emerged. Some participants suggested that for the component to be presented in a culturally appropriate manner in the workshop, a stronger connection between mindfulness training and religious components (e.g., prayer) is needed. As one participant remarked in the survey,

“Consider how spiritual and religious values and practices such as prayer can be incorporated into the practice of mindfulness. Doesn't sound like the skill has been culturally adapted, it sounds just as other mindfulness interventions for non-Hispanic and non-Latinos.”

While this class of perspectives viewed the vast heterogeneity in religion as an opportunity to optimize the cultural appropriateness of mindfulness through adaptation, another cluster of viewpoints referenced this very heterogeneity as a threat to the component's cultural appropriateness. These voices argued that mindfulness training is inherently not culturally appropriate because it is incompatible with different religions across Latinx communities; this sentiment would then suggest that the component need not be adapted, but rather replaced by a religious component or omitted entirely. As a survey participant shared,

“This [mindfulness] is... what ‘pray’ and ‘listening and talking to God’ is in Catholic culture. So 'mindfulness' from that deeply connected cultural perspective seems to me like a cartoon version of true spirituality and connection with the Universe...Clinically I don't think that...mindfulness has ever landed well in my Hispanic patients...Catholic tradition and forms of prayer are vast and rich, and I wonder if encouraging patients to pray and connect with God in a mature and healthy way would be more effective than pushing them an alien tradition that has no cultural ground in them.”

The final cluster of perspectives argued that mindfulness training is indeed culturally appropriate if the practice continues to be taught neutrally, void of any religious attributions or associations, drawing a sharp contrast to the previous two perspectives. This viewpoint recognized the vast heterogeneity in religion as the very rationale for adopting a neutral (i.e., more generalized) approach that respects all religious affiliations by avoiding any link between the component and religion from the outset. Many focus group participants endorsed this perspective, emphasizing, “More than anything, it's about teaching the technique.”

Participants also highlighted experiences with/of acculturative stress as another contextual factor to consider in ensuring the cultural appropriateness of the component. Similar

to the nature of some of the religion perspectives, several participants emphasized that, for mindfulness training to be culturally appropriate, it should be directly contextualized or situated within discussions of acculturative stress. One survey participant noted, “This [mindfulness] can border on toxic positivity. Pain first needs to be recognized before coping skills can be employed.” Similarly, another shared, “Decontextualized mindfulness can be perceived as invalidating” while yet another advocated for incorporating the “...mindful acceptance of the reality of acculturative stress.”

Moreover, participants identified the contextual fit between the terminology itself (i.e. “mindfulness training”) and the target population (i.e., Latinx communities) as another element influencing the cultural appropriateness of the component. Participants shared a variety of alternative terms that may resonate more with Latinxs including “relaxation,” “be conscious/live consciously,” and “meditate.” Another participant proposed the term “emotional intelligence,” expressing how “being conscious of [our] own emotions and how to manage them” is a concept that could resonate more with Latinxs.

Pillar-Building Integration

High Acceptability

The pillar-building integration yielded notable points of convergence. First, the mindfulness training component was perceived as acceptable. The quantitative data highlights the component’s acceptability on a more general level, deeming it highly appealing and agreeable. This sentiment maps onto the qualitative feedback that provided more specific explanations for the component’s agreeableness, including its actionability, accessibility, and inclusion of appealing components like gratitude.

Views on Religion and Acculturative Stress Modulate Perceived Appropriateness of Mindfulness Training

Second, greater attention to religion and acculturative stress appears to be important for optimizing the cultural appropriateness of mindfulness training. Specifically, it is likely that the qualitative feedback showcased, or helped explain, some of the observed quantitative nuances across the three dimensions of appropriateness. For instance, strong opinions regarding the role of religion may help explain the relatively lower rating observed for the appropriateness dimension “*acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics.*” Consequently, this may suggest that a “one-size-fits-all” presentation of the mindfulness component is not appropriate and rather, may require attending to the individual and setting in which the component is employed to tailor to those preferences. Similarly, the appropriateness dimension “*adequately addresses the topic of acculturative stress*” also received lower average and median ratings which may reflect the qualitative feedback emphasizing the potential benefit of more explicit attention to acculturative stress within this component. Interestingly, this belief seemed independent of the third dimension of appropriateness, suggesting that the component still “*holds the potential to have a positive health impact by reducing acculturative stress.*” This dimension received higher average and median ratings, aligning with the broader scholarly understanding that mindfulness can reduce acculturative stress. Thus, participants seemed to believe mindfulness could still be culturally useful in reducing acculturative stress while also believing that this intervention’s target-acculturative stress- could be more directly integrated in this component. The strong perceptions on religion and acculturative stress may further be reflected in the frequency distribution of

ratings, which shows a small but notable concentration of “strongly disagree” and “disagree” responses.

Values Assessment

Quantitative Results

The component appeared to be highly “*agreeable and appealing*” among survey participants ($M=4.45$, $SD=.827$; $m=5.00$). Individuals seemed to strongly agree that the component “*acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics*” ($M=4.47$, $SD=.763$, $m= 5.00$) and “*holds the potential to have a positive health impact by reducing acculturative stress*” ($M=4.44$, $SD=.826$, $m=5.00$). The appropriateness dimension “*adequately addresses the topic of acculturative stress*” observed a slightly lower rating compared to the other two dimensions ($M=4.21$, $SD=.890$, $m=4.00$). See Table 3 below for the component’s full distribution of ratings, including frequency of responses.

Table 3: Values assessment ratings			
	M(SD); m(IQR)	N	%
Acceptability (<i>agreeable and appealing</i>)	4.45 (.827); 5 (4-5)	--	--
(1) Strongly disagree	--	2	2.7
(2) Disagree		0	0
(3) Neither disagree nor agree		4	5.3
(4) Agree		25	33.3
(5) Strongly agree		44	58.7
Appropriateness (<i>respects Latinx values</i>)	4.47 (.763); 5 (4-5)	--	--
(1) Strongly disagree	--	1	1.4
(2) Disagree		0	0
(3) Neither disagree nor agree		6	8.1
(4) Agree		23	31.1
(5) Strongly agree		44	59.5
Appropriateness (<i>adequately addresses acculturative stress</i>)	4.21 (.890); 4 (4-5)	--	--
(1) Strongly disagree	--	1	1.3
(2) Disagree		3	4.0
(3) Neither disagree nor agree		8	10.7
(4) Agree		30	40.0
(5) Strongly agree		33	44.0
Appropriateness (<i>has potential to have positive health impact by reducing acculturative stress</i>)	4.44 (.826); 5 (4-5)	--	--
(1) Strongly disagree	--	2	2.7
(2) Disagree		0	0
(3) Neither disagree nor agree		4	5.3
(4) Agree		26	34.7
(5) Strongly agree		43	57.3

Qualitative Results

Participants appreciated several aspects of values assessment. On a broader level, they perceived the component to be a fundamental component of the intervention. As one survey participant expressed, “Examining values is so important, and personally life changing for me.” Other survey participants highlighted specific aspects of the values assessment component that they particularly enjoyed. For example, one survey participant, referencing the distinction between values (i.e., aspirational principles) and goals (i.e., achievable targets), shared

“The goal setting following values [identification] is the most important part... [It] relates to clear habits and milestones and should be the highlight [of the component]. Without that, there is no clear action to take.”

Participants also expressed several insights and corresponding recommendations for how to optimize the cultural appropriateness of the values assessment component. In the survey, some participants called attention to the word “values” (*valores* in Spanish) itself and its multifaceted meaning and connotation across different contexts. For example, one survey participant noted, “For participants with Catholic upbringings ‘valores’ could be seen as connected to virtues that they should have (rather than values that are preferences that guide their lives).” Focus group participants described how the complexity of the word is further compounded by the reality that the idea of evaluating and exploring values has been historically underexplored and challenging to navigate across Latinx communities. As one focus group participant explained,

“Have patience with the community with that word to assimilate [it]. Like ‘mental health’ it is not easy to digest for the community...historically it [mental health] has not been talked about much and [now] it has [been] assimilated with time.”

Thus, focus group participants highlighted this layered and perhaps unfamiliar meaning of “values” not as a threat to cultural appropriateness, but as an opportunity to increase knowledge and awareness of the topic in the community. For example, participants provided alternative terminology that we may use to help describe or contextualize the concept for the community. Focus group participants suggested describing values as “your way of living” (*manera de vivir* in Spanish) or “your rules as a mother or father” (*tus reglas como madre o padre* in Spanish). While some of these suggested terms gravitated toward a more familial-focused interpretation of values, other recommendations reflected a more individual focus. For instance, one focus group participant proposed terms like “introspective thinking” or “internal processing and beliefs” as concepts that may resonate more with the community.

Across the full spectrum of individual and family-oriented values, participants emphasized that particularly in Latinx culture, values are inherently intimate and personal. As a result, this can lead to interpersonal conflict when the values one holds do not align with those of others. Therefore, participants recommended reiterating group norms (i.e., shared expectations and standards) prior to intervention activities related to values. Among the recommended group norms were no judging, no giving advice or trying to impose values on others, and respectfully listening while others are speaking without interjecting.

Lastly, participants provided feedback specific to the behavioral or “action” (i.e., concrete step) element of the values assessment component. Participants examined how acculturative stress may impede an individual’s ability to pursue value-aligned behavior in their life. As one survey participant underscored,

“This [component] is probably one of the most challenging components given the nuance in moving forward in alignment with your values even in the face of uncontrollable acculturative stressors - but I believe [it] can be immensely valuable.”

Thus, this feedback seemed to emphasize how a culturally appropriate presentation of this component will magnify how structural realities may complicate the “values-to-goals-to-action” model of values assessment. Notably, some participants offered additional insights into the “action” element of this component from a more organizational perspective. Specifically, one survey participant suggested, “I would ask you to consider having participants consider the actions that indicate their values before talking about the actual values categories (more of an inductive approach) so that the broad categories remain connected to reality.” This directional process, contrary to the current model of values assessment, proposes a conceptual shift or supplementary activity that allows individuals to arrive at their values through an assessment of their actions.

Pillar-Building Integration

High Acceptability

The quantitative and qualitative data converged on the high perceived acceptability of the values assessment component. Specifically, the component evidenced high average and median acceptability (i.e., agreeableness and appeal). These results are consistent with qualitative findings that identified the component and its subcomponents (e.g., goal setting) as highly important and satisfactory.

Values Assessment was Perceived as Both a Culturally Challenging and Appropriate

Exercise

A second point of convergence represents the component's high cultural appropriateness; specifically, the quantitative and qualitative datasets converged on the notion that cultural challenges and cultural appropriateness are not mutually exclusive (i.e., just because the component may present cultural challenges, does not negate its cultural appropriateness). We observed this principle in the focus group, where participants believed that, despite the topic of values being historically unaddressed or unfamiliar, it nonetheless is culturally relevant and useful. This was further supported by the quantitative data, which revealed that each dimension of cultural appropriateness was well received. Notably, the only dimension which did not receive a median rating of 5.00 was the dimension "*adequately addresses acculturative stress*" which observed a lesser concentration of responses in the "strongly agree" category than the other dimensions. This pattern may reflect some of the qualitative concerns raised about the challenges of pursuing value-aligned behavior in the face of acculturative stressors. Interestingly, some of the qualitative feedback we received may point to how we can better target this dimension (i.e., by better addressing acculturative stress through values assessment). For example, there was a suggestion to use an inductive approach within this component, focusing on how one arrives at their values through actions. This approach may actually strengthen the link between values assessment and acculturative stress by centering real life experiences or as the participant stated, "realities" of acculturative stress. Thus, this approach may allow individuals to more organically discover their values in the context, or amid, acculturative stressors.

Structured Problem-Solving

Quantitative Results

Structured problem-solving was perceived as highly "*agreeable and appealing*" ($M=4.38$, $SD=.775$; $m=5.00$). Participants generally agreed that the component "*acknowledges,*

respects, and incorporates cultural values, traditions, and beliefs of first- and second-generation Latinxs/Hispanics” ($M=4.05$, $SD=.956$; $m=4.00$); “*adequately addresses acculturative stress*” ($M=4.19$, $SD=.855$; $m=4.00$); and “*holds the potential to have a positive health impact by reducing acculturative stress*” ($M=4.38$, $SD=.735$; $m=4.00$). See Table 4 for the component’s full distribution of ratings, including frequency of values.

Table 4: Structured problem-solving ratings			
	M(SD); m(IQR)	N	%
Acceptability (<i>agreeable and appealing</i>)	4.38 (.775); 5 (4-5)	--	--
(1) Strongly disagree	--	1	1.4
(2) Disagree	--	0	0
(3) Neither disagree nor agree	--	7	9.6
(4) Agree	--	27	37.0
(5) Strongly agree	--	38	52.1
Appropriateness (<i>respects Latinx values</i>)	4.05 (.956); 4 (4-5)	--	--
(1) Strongly disagree	--	2	2.7
(2) Disagree	--	2	2.7
(3) Neither disagree nor agree	--	13	17.8
(4) Agree	--	29	39.7
(5) Strongly agree	--	27	37.0
Appropriateness (<i>adequately addresses acculturative stress</i>)	4.19 (.855); 4 (4-5)	--	--
(1) Strongly disagree	--	1	1.4
(2) Disagree	--	2	2.7
(3) Neither disagree nor agree	--	9	12.2
(4) Agree	--	32	43.2
(5) Strongly agree	--	30	40.5
Appropriateness (<i>has potential to have positive health impact by reducing acculturative stress</i>)	4.38 (.735); 4 (4-5)	--	--
(1) Strongly disagree	--	1	1.4
(2) Disagree	--	0	0
(3) Neither disagree nor agree	--	5	6.8
(4) Agree	--	32	43.2
(5) Strongly agree	--	36	48.6

Qualitative Results

Participants pointed to several favorable qualities of the structured problem-solving component. Particularly, participants endorsed the formulaic problem-solving process as didactic and easy to follow. As one focus group participant shared,

“This [structured problem-solving] is stupendous to me. The matter is practical. There are people who think sequentially... [and people who] perceive everything at once...it’s very instructive for the person that cannot [think sequentially]. This gives them another perspective.”

Another focus group participant echoed this viewpoint, expressing, “For the programs that I have seen, it’s very digestible.”

While many participants voiced agreeable aspects of the structured problem-solving component, several also offered recommendations for enhancing its cultural appropriateness. Specifically, while the sequential, linear nature of the practice was seen as acceptable or a strength, some believed this linear process could benefit from more flexibility to appropriately accommodate and engage the diverse problem-solving patterns and preferences within the Latinx community. For example, one survey participant shared,

“Not able to tell how our Latino beliefs, values and traditions come into play with Structured Problem Solving...such as how we use or refer to ‘dichos’ or short story-telling as we process and deal with a problem facing us or someone we are trying to help-before jumping into this type of ‘linear’ approach to problem-solving which is more of a Caucasian norm. Need to remember generational differences in our Latinos, with older Latinos being more ‘intuitive’ and wanting to contemplate a situation, maybe using ‘dichos’ and ‘historias’ to help define the problem or situation, before acting.”

Thus, this perspective suggests an opportunity for modifications that could enhance the cultural application and comprehension of the structured problem-solving component (i.e., by incorporating cultural elements like narratives or storytelling). Participants proposed additional modifications to the component's structure, noting that the individual-oriented nature of the practice may not resonate with Latinx values, which tend to favor social or group methods of problem-solving. As a result, some suggested incorporating, or at least acknowledging, group problem-solving within this component. One survey participant mentioned, "Many times, Latinas depend on more opinions than just themselves [to solve problems]" and another similarly remarked, "Suggest what the role of the group is in the problem-solving process."

Further, several participants recognized that Latinx communities face deeply entrenched, systemic, and structural problems that often are uncontrollable, which may jeopardize or limit the utility of the structured problem-solving technique. Despite background information provided to participants explaining that the component aims to address these challenges, participants' apprehension about this component remained a notable theme. One survey participant emphasized,

"The only hesitation here might be the complexity of problems that have both solvable and unsolvable components and helping participants to identify what they do have control over. Sometimes situations/problems can be partially solved or improved, but not completely, which makes the process a bit more nuanced."

Another participant who completed the survey reiterated, "People may be uncomfortable sharing about or may experience stress by thinking about problems, as many problems faced by immigrants or refugees are harder to 'solve' than problems faced by long-term settled residents."

These perspectives suggest ongoing concerns that there is a risk of the structured problem-solving component oversimplifying or invalidating complex problems that have no clear resolution. Thus, it seemed important to participants to maximize session content and time that explores the nuances of control implicated in navigating complex problems. Focus group participants echoed similar concerns, as evidenced by inquiries into how resources are offered within the scope of this component. One asked, “What community resources do you have? Because many [Latinxs/Hispanics] come with more than one problem.” Some participants advocated for a more intentional integration of resources within this component, recognizing the imperative link between identifying solutions and available resources. One survey participant suggested, “As part of this module, I think it would be crucial to discuss resources that are available in the community to help solve problems. I can see that it might be challenging to engage in identifying solutions if one isn't knowledgeable about supports in the community.”

Pillar-Building Integration

High Acceptability

The first pillar-building theme that emerged highlights the acceptability of the structured problem-solving component. The quantitative results indicate that participants strongly agreed that the component is agreeable and appealing; this data is in-line with the qualitative feedback we received identifying the component’s strengths, specifically that the practice is practical, informative, and digestible.

Enriching “Form” may Optimize Appropriateness of Structured Problem-Solving

A second point of convergence represents another pillar-building theme; while structured problem-solving is a generally agreeable process, modifications to its form may enhance the component’s cultural suitability and fit for Latinxs/Hispanics. Specifically, the quantitative data

demonstrates that participants rated each dimension of appropriateness highly, with approximately equal concentrations of “agree” and “strongly agree” responses. These ratings are consistent with the qualitative feedback, which calls for minimal yet meaningful modifications to the component. Unlike the feedback we received for mindfulness- which in some cases called for more drastic changes or even the omission of the component- feedback regarding structured problem-solving looked to enrich the current presentation of the component (e.g., incorporating cultural traditions and storytelling into the practice, addressing group-based problem-solving methods) and to expand on elements already rooted within the component (e.g., integrating resource identification into the component and further developing “control” strategies within the practice).

Interpersonal Skills Training

Quantitative Results

Survey participants evaluated the interpersonal skills training component as highly “agreeable and acceptable” ($M=4.45$, $SD=.800$; $m=5.00$). The majority also strongly agreed that the component fulfills each dimension of cultural appropriateness: “*acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second-generation Latinxs/Hispanics*” ($M=4.32$, $SD=.885$, $m= 5.00$); “*adequately addresses the topic of acculturative stress*” ($M=4.38$, $SD=.907$, $m=5.00$) and “*holds the potential to have a positive health impact by reducing acculturative stress*” ($M=4.45$, $SD=.862$, $m=5.00$). See Table 5 below for the component’s full distribution of ratings and frequency of values.

Table 5: Interpersonal skills training ratings			
	M(SD); m(IQR)	N	%
Acceptability (<i>agreeable and appealing</i>)	4.45 (.800); 5 (4-5)	--	--
(1) Strongly disagree	--	2	2.7
(2) Disagree		0	0
(3) Neither disagree nor agree		2	2.7
(4) Agree		28	38.4
(5) Strongly agree		41	56.2
Appropriateness (<i>respects Latinx values</i>)	4.32 (.885); 5 (4-5)	--	--
(1) Strongly disagree	--	1	1.4
(2) Disagree		2	2.8
(3) Neither disagree nor agree		8	11.1
(4) Agree		23	31.9
(5) Strongly agree		38	52.8
Appropriateness (<i>adequately addresses acculturative stress</i>)	4.38 (.907); 5 (4-5)	--	--
(1) Strongly disagree	--	1	1.4
(2) Disagree		3	4.1
(3) Neither disagree nor agree		6	8.2
(4) Agree		20	27.4
(5) Strongly agree		43	58.9
Appropriateness (<i>has potential to have positive health impact by reducing acculturative stress</i>)	4.45 (.862); 5 (4-5)	--	--
(1) Strongly disagree	--	2	2.7
(2) Disagree		1	1.4
(3) Neither disagree nor agree		3	4.1
(4) Agree		24	32.4
(5) Strongly agree		44	59.5

Qualitative Results

Several aspects of the interpersonal skills training component were endorsed as acceptable by participants. In particular, participants appreciated this component's target (i.e., purported mechanism) of social connectedness, with one survey participant expressing, "I love the idea of the social connectedness part and helping people get connected via volunteering and other events. This sounds like an excellent way to foster resilience," while another remarked, "This is a key issue and was addressed well." Participants also favored the strong familial focus of this component. One survey participant shared, "Really important focus on addressing family conflict and stressors."

In fact, participants appeared to gravitate towards familial conflict as a culturally relevant and useful topic to explore within this component. Specifically, participants underscored the importance of interpersonal training/skills as it relates to three interconnected types of "balance" or "negotiation" within the familial unit, often involving parent-child relationships. First, participants spoke of balancing permissibility (i.e., flexibility) with authority (i.e., setting boundaries and limits) in the home. They highlighted the cultural importance of interpersonal skills that capture this balance; as one focus group participant shared, "One thing is authority, and another is authoritarianism."

Second, participants underlined the utility of training focused on values-based negotiation and conflict, particularly the balance between familial or societal values and individualism. Participants also recognized that values are deeply grounded in cultural traditions and patterns, some of which may be considered problematic (e.g., machismo) but still accepted at the familial

or societal level. Therefore, negotiating which societal values should be challenged versus those which should be preserved was deemed crucial.

Thirdly, and closely related to values-based negotiation, participants emphasized the significance of negotiating biculturalism within the family. This is particularly important, they noted, as Latinx children and adolescents are often more exposed to different cultures outside of the home, creating intergenerational gaps and interpersonal disconnect. Thus, interpersonal skills that center how to navigate negotiation that arises from these competing pressures (assimilation and preservation of homeland heritage) are fundamental. As one survey participant shared,

“I have heard from community members that Latino parents commonly feel difficulties connecting with their teens, so...highlighting these parent-child gaps (for participants with children) [is] really important.”

Pillar-Building Integration

High Acceptability

Data integration revealed two points of convergence. The first pillar-building theme identified the component as highly acceptable; the quantitative data indicated that interpersonal skills training is highly agreeable and appealing, a finding further illustrated by the qualitative data underlining several acceptable qualities of the component, such as its function in fostering social connection and strengthening familial relationships.

Familial Negotiation and Balance: Key Factors Driving Appropriateness of

Interpersonal Skills Training

The second point of convergence illustrates that conflicts within familial relationships – such as negotiating boundaries/limits, values, and biculturalism- appear to be key targets of cultural appropriateness for this component. Participants described what they believe to be key

principles of culturally grounded interpersonal skills training; these principles in fact underpin specific activities in the intervention which may explain why quantitative ratings across the dimensions of cultural appropriateness were high. For example, the qualitative focus on negotiating values and biculturalism aligns with session activities on navigating intergenerational gaps and addressing interpersonal conflict within the family, while feedback on balancing flexibility and authority supports the component's emphasis on perspective-taking and reaching agreements. Thus, interpersonal skills training appears to be culturally appropriate because it incorporates these key principles, thus reinforcing the current model/structure of the component.

Psychoeducation

Quantitative Results

Survey participants tended to strongly agree that psychoeducation is “*agreeable and appealing*” ($M=4.41$, $SD=.843$; $m=5.00$). They generally agreed that psychoeducation “*acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics*” ($M=4.30$, $SD=.840$, $m= 4.00$); “*adequately addresses the topic of acculturative stress*” ($M=4.18$, $SD=.881$, $m=4.00$) and “*holds the potential to have a positive health impact by reducing acculturative stress*” ($M=4.27$, $SD=.865$, $m=4.00$). See Table 6 below for the component's full distribution of ratings and frequency of values.

Table 6: Psychoeducation ratings			
	M(SD); m(IQR)	N	%
Acceptability (<i>agreeable and appealing</i>)	4.41 (.843); 5 (4-5)	--	--
(1) Strongly disagree		2	2.7
(2) Disagree		1	1.4
(3) Neither disagree nor agree	--	2	2.7
(4) Agree		29	39.2
(5) Strongly agree		40	54.1
Appropriateness (<i>respects Latinx values</i>)	4.30 (.840); 4 (4-5)	--	--
(1) Strongly disagree		2	2.7
(2) Disagree	--	1	1.4
(3) Neither disagree nor agree		3	4.1
(4) Agree		35	47.3
(5) Strongly agree		33	44.6
Appropriateness (<i>adequately addresses acculturative stress</i>)	4.18 (.881); 4 (4-5)	--	--
(1) Strongly disagree		2	2.7
(2) Disagree	--	1	1.4
(3) Neither disagree nor agree		8	10.8
(4) Agree		34	45.9
(5) Strongly agree		29	39.2
Appropriateness (<i>has potential to have positive health impact by reducing acculturative stress</i>)	4.27 (.865); 4 (4-5)	--	--
(1) Strongly disagree		1	1.4
(2) Disagree	--	2	2.7
(3) Neither disagree nor agree		8	10.8
(4) Agree		28	37.8
(5) Strongly agree		35	47.3

Qualitative Results

Participants generally endorsed psychoeducation as an agreeable component. Specifically, they appreciated how the component aims to increase one's own knowledge and understanding about stress and resilience. As one participant remarked "It [psychoeducation] leans into the evidence that sometimes knowing alone can help people begin to feel less overwhelmed... they understand what they are going through."

In the context of *Cultivating Resilience* being a prevention and promotion program, participants believed it would be appropriate for the component to broaden its scope to include and optimize additional areas of education specific to mental health issues. Specifically, participants emphasized the importance of not assuming that mental health issues (e.g., depression and anxiety) are familiar topics across Latinx communities. As such, they recommended our team incorporate information about several different dimensions of mental health as part of the psychoeducation component. First, participants commented on the importance of including psychoeducational content related to mental health symptoms, signals, and triggers that intervention group members may be experiencing. Participants described the significance of this content, which may help individuals better identify the physical and mental manifestations of mental health conditions in their own lives. Further, participants explored the value of this content as a potential informal diagnostic tool for facilitators to assess the level of risk and pathology present in their group. In this way, including information about (and inquiring into) symptoms would not aim to impose diagnoses unto intervention members, but rather to enhance intervention facilitation by helping facilitators better gauge the needs of their members and provide tailored informational supports accordingly.

Moreover, participants shared that there should be psychoeducation about help-seeking awareness and promotion. Specifically, participants noted that given cultural patterns of not seeking treatment, the intervention should not only focus on identifying symptoms but also on recognizing when those symptoms reach a level that warrants seeking help, particularly in a way that mitigates or prevents crisis situations. For some, “help” may mean seeking workshop-focused intervention, while for others this may mean pursuing formal mental health services (e.g., therapy). Relatedly, participants suggested incorporating psychoeducational elements that specifically address what therapy is, including important distinctions between therapy and workshop-based interventions. Participants underscored the value of this specific knowledge acquisition, as it can help the community recognize when their unique mental health needs may require formal services beyond workshop prevention and promotion.

Participants further recommended that psychoeducation include information on destigmatizing mental health, noting this content as particularly valuable in countering cultural patterns of stigma and shame often associated with mental health topics in many Latinx communities. One focus group participant emphasized, “Normalize mental health whenever there is an opportunity [with] respect and empathy.” A survey participant shared this sentiment, expressing, “I think it's so important for folks to know that these feelings are normal, that they happen and there is a 'thing' going and you aren't crazy!”

Lastly, many participants expressed the view that psychoeducation should more strongly address the role of social drivers of health in creating and exacerbating mental health issues for Latinx immigrants. As one survey participant shared, “It may also be helpful to specifically discuss ways in which communities are marginalized and intersectionality.” Others pointed to the possibility of drawing from certain theories, such as “... incorporating critical consciousness,” an

approach for intervention group members to understand their identities as a product of the contexts in which they live, their positionality within those contexts, and the subsequent impacts on mental health. As such, participants generally desired psychoeducation that deliberately targets and articulates health inequity above and beyond its symptoms and effects.

Pillar-Building Integration

High Acceptability

Quantitative and qualitative datasets yielded high acceptability as a pillar-building theme for psychoeducation. Over half of survey participants strongly agreed that the component is agreeable and appealing. Qualitative feedback shed light on acceptable qualities of the component; specifically, participants described the component's underlying mechanism, knowledge acquisition, as a key factor they found favorable.

Extending Psychoeducational Content to Dimensions of Mental Health may Increase

Perceived Appropriateness

There appeared to be a desire for psychoeducation to increase knowledge acquisition on a broader range of topics related to dimensions of mental health which would in turn benefit dimensions of cultural appropriateness. Each dimension of cultural appropriateness observed high quantitative ratings, suggesting that in general, participants agreed the psychoeducation component respects Latinx values, adequately addresses acculturative stress, and has the potential to have a positive health impact by reducing acculturative stress. Interestingly, the qualitative feedback leaned more toward mental health education rather than acculturative stress-oriented education alone. Together, this may suggest that psychoeducation ought to address the co-occurrence of acculturative stress and mental health conditions to fully respect the range and interaction of experiences facing intervention members. Moreover, the qualitative feedback to

create more space for education focused on the interlocking nature of systemic inequities, intersectional identity formation, and mental health, may illustrate additional nuanced topics that would be culturally appropriate to explore in conjunction with education on acculturative stress.

Connection to Community Resources

Quantitative Results

Survey participants appeared to agree that connection to community resources is “agreeable and appealing” ($M=4.28$, $SD=.958$; $m=4.00$). Over half of participants strongly agreed with each dimension of appropriateness: “*acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second-generation Latinxs/Hispanics*” ($M=4.26$, $SD=.986$, $m= 5.00$); “*adequately addresses the topic of acculturative stress*” ($M=4.39$, $SD=.919$, $m=5.00$) and “*holds the potential to have a positive health impact by reducing acculturative stress*” ($M=4.51$, $SD=.798$, $m=5.00$). See Table 7 below for the component’s full distribution of ratings and frequency of values.

Table 7: Connection to community resources ratings			
	M(SD); m(IQR)	N	%
Acceptability (<i>agreeable and appealing</i>)	4.28 (.958); 4 (4-5)	--	--
(1) Strongly disagree	--	4	5.4
(2) Disagree		0	0
(3) Neither disagree nor agree		2	2.7
(4) Agree		33	44.6
(5) Strongly agree		35	47.3
Appropriateness (<i>respects Latinx values</i>)	4.26 (.986); 5 (4-5)	--	--
(1) Strongly disagree	--	2	2.7
(2) Disagree		3	4.1
(3) Neither disagree nor agree		7	9.6
(4) Agree		23	31.5
(5) Strongly agree		38	52.1
Appropriateness (<i>adequately addresses acculturative stress</i>)	4.39 (.919); 5 (4-5)	--	--
(1) Strongly disagree	--	3	4.1
(2) Disagree		0	0
(3) Neither disagree nor agree		4	5.4
(4) Agree		25	33.8
(5) Strongly agree		42	56.8
Appropriateness (<i>has potential to have positive health impact by reducing acculturative stress</i>)	4.51 (.798); 5 (4-5)	--	--
(1) Strongly disagree	--	2	2.7
(2) Disagree		0	0
(3) Neither disagree nor agree		2	2.7
(4) Agree		24	32.4
(5) Strongly agree		46	62.2

Qualitative Results

Participants recognized several favorable qualities of connecting intervention members to community resources. First, participants liked that resources are provided and revisited in an iterative manner throughout the course of the intervention. As one survey participant expressed,

"10/10. This is an excellent and important module. I am so excited to hear it...will be revisited throughout. I found myself worrying that there would not be enough to overcome the very real structural barriers that people may encounter, but seeing this video and the explanation makes me feel confident this will be a helpful and integral part of the intervention."

Another survey participant shared this enthusiasm about the component, referencing how the provision of resources can in fact promote intervention attendance and retention,

"Very important piece. I loved hearing that part of this is introduced in the very first session. Very, very important. I find that when families are connected with resources for immediately pressing needs, they are better able to attend clinic sessions, and they feel that you care."

Participants further appreciated that the research team intentionally seeks out and provides resources for undocumented immigrants, recognizing both the lack of-and need for- these specific services in the community. One survey participant remarked, "I'm happy to hear the topic of [connecting] undocumented individuals to resources, as most resources are not offered to these people."

Participants underscored how the research team's intentionality and initiative is integral to improving the appropriate and successful connection between workshop participants and

community resources. Many offered suggestions that spoke to the significance of this intentional approach, defined by a constant willingness to go above and beyond to identify and expand the availability of resources for the community. First, participants highlighted the responsibility of the research team to proactively search for and provide more resources. As one survey participant suggested, this commitment is of utmost importance because "the low availability of resources in some communities to meet needs [could] limit the impact of this component." Specifically, the research team ought to take the initiative in exploring resources outside of the Milwaukee area as a way of increasing options available to intervention members who may be from different demographic areas. Further, participants emphasized the importance of increasing both the number and transparency of resources that are free of cost on our resource list in anticipation of- and to reduce- barriers and burden. One focus group participant remarked, "Increase the resources [and] decrease all the bureaucratic steps to truly achieve the goal of helping the community." In this way, participants suggested that the research team should serve as an active intermediary in ensuring the continuity of connection to resources.

Participants additionally spoke of continuing to proactively form alliances with groups/organizations, including with student groups/trainees (e.g., as a way to incorporate forms of short-term triage) and community health workers (with the understanding, however, that they too may be limited and at capacity). One focus group participant remarked, "Make alliances to open new resources," a sentiment reinforced by a survey participant's comment to "engage professionals directly and/or have resource fairs." Notably, the theme of initiative was multidimensional; participants described the importance of expanding community events to equip the community with tools and knowledge necessary so that they themselves can take the initiative in seeking out resources and navigating systems. One survey participant's feedback

captured this multidimensional nature of initiative, stating, "Regular informational talks can help people stay informed about the health resources that exist in the communities where they live." Thus, while providing regular community lectures reflects the initiative of the research team, the ultimate goal described by participants was to strengthen knowledge acquisition and self-initiative among community members.

Pillar-Building Integration

High Acceptability

Both datasets demonstrated high acceptability for the connection to community resources component. Quantitatively, participants mostly strongly agreed or agreed that the component is agreeable and appealing. These findings are consistent with the qualitative feedback which yielded several favorable aspects of the component, including how it is revisited throughout the duration of the intervention and how it is inclusive of resources for undocumented immigrants.

Connection to Community Resources is Culturally Appropriate When Driven by Initiative and Intentionality

Quantitative and qualitative datasets converged on high appropriateness. Quantitatively, survey participants tended to strongly agree that the component respects Latinx values, adequately addresses acculturative stress, and has the potential to have a positive health impact by reducing acculturative stress. Qualitatively, participants focused on the imperative role of initiative and intentionality in making this connection culturally appropriate. Specifically, participants underscored how as a research team, there is always more we can do to expand available resources, reduce barriers, and build partnerships. These aspects of approach, then, may be key targets in ensuring the connection to community resources effectively serves the needs related to acculturative stress.

Perceptions of Potential Demographic Adaptations

During the process of conducting rapid preliminary analyses (of the survey) to develop the semi-structured interview guide for our first focus group, we unveiled an unanticipated domain of interest. Open-ended feedback throughout the survey raised comments and considerations related to the possibility of adapting *Cultivating Resilience* for different demographic groups. Interestingly, we received a high number of these comments despite there being no designated question in the survey addressing demographic adaptations. We further explored this topic in our first focus group; herein, we present key qualitative results. Participants were strong proponents of the intervention being adapted for a host of demographic groups. While the pilot RCT of *Cultivating Resilience* valued bringing workshop participants together from different generational and age groups, the feedback we received suggests a shift from this first iteration of the intervention. Interestingly, survey and focus group participants felt that this structure- groups of mixed generations and ages- might inhibit, rather than facilitate, group connection. Alternatively, they believed that adapting the material for different demographic groups would honor group differences, promote group connection, and allow for a more focused discussion of intervention content/topics.

For example, some proposed adaptations that offer the intervention for groups based on different language preferences and proficiencies. In this way, there would be bilingual and English- speaking groups in addition to groups in Spanish. One survey participant suggested, "...offering English-language as well for folks who feel less comfortable talking about these topics in Spanish or have limited proficiency." Another survey participant commented, "They [the research team] should try to ensure that the intervention can be bilingual because some...born here [the US] do not understand Spanish very clearly." Further, there were

recommendations to provide the intervention for different groups based on generational status. One participant from the survey explained,

"I think that first v. second generation immigrants would have different experiences with acculturative stress (e.g., different language barriers, experiences with occupational and health systems), so I could see it being helpful to separate groups based on generational status, [or] at least having the opportunity to break into smaller groups during a larger session."

Participants shared similar ideas related to potential adaptations based on age categories. One survey participant acknowledged, "This [the intervention] might be helpful to people younger than 18 (with some developmental adaptations)." Another proposed additional age-specific groups, "I think an adolescent group, one that is specific for young adults, and one specific for older adults would be interesting... While I respect the beauty of intergenerational work, I think topics could be focused more in these groups." The value in exploring age-focused topics within the scope of the intervention was shared by yet another survey participant who elaborated, "Older Spanish speaking adults will have unique needs [which] may decrease the connection between participants as they are in different stages of life and may have unique values and perspectives towards mental health." This sentiment was also expressed in the focus group; one member who advocated for age-specific groups focused more on how this approach may honor and respect group differences. The participant shared,

"When I introduce myself, I say 'I'm [name].' When I'm with younger people I have to say 'she/her' [whereas with] women of 50, 60 years, whom I don't have to tell my pronouns, it's enough to say, 'I'm Mexican.' When working with young people we have to honor [those preferences]."

For the greater portion of the discussion on potential adaptations, focus group participants explored the possibility of adapting the intervention for men specifically. This feedback came in response to the recognition that the pilot RCT was comprised predominantly of women. Participants endorsed the idea of offering men-only groups of the intervention, urging that efforts continue even in the face of inherent challenges with recruiting men for workshops, a deep-rooted cultural problem that is hard to solve; as one participant highlighted, “Men don’t talk about their problems...it’s something that has happened for many, many years and it’s going to be difficult to resolve, but...it starts with younger generations.” To help overcome obstacles with men enrollment, participants proposed targeted marketing strategies, including augmenting the presence of male identities in intervention recruitment flyers and materials. Others stressed the importance of framing the intervention in ways that align with traditionally male roles, values, and interests. One participant drew attention to the connotations associated with workshops, suggesting it may be wise to “camouflage” the nature of the intervention because “when it’s a workshop, it sounds more feminine...it’s always a more feminine energy.” Another participant further elaborated on strategies that tailor to men and their motivations, proposing ways to frame the intervention, “about resolving the problems of your family, of your home...to make a ‘club’ for the head of the household.” It is worth acknowledging that some of this feedback may reinforce traditional gender stereotypes and assumptions, reflecting limited and binary views of masculinity.

Lastly, participants expressed that certain adaptations of the intervention should not be pursued. Specifically, participants did not approve of offering an adaptation of the intervention for couples or partners, emphasizing that such efforts would prove both challenging and harmful

given the potential cases of intimate partner violence that may arise and that would be better addressed by formal services rather than a workshop-based intervention.

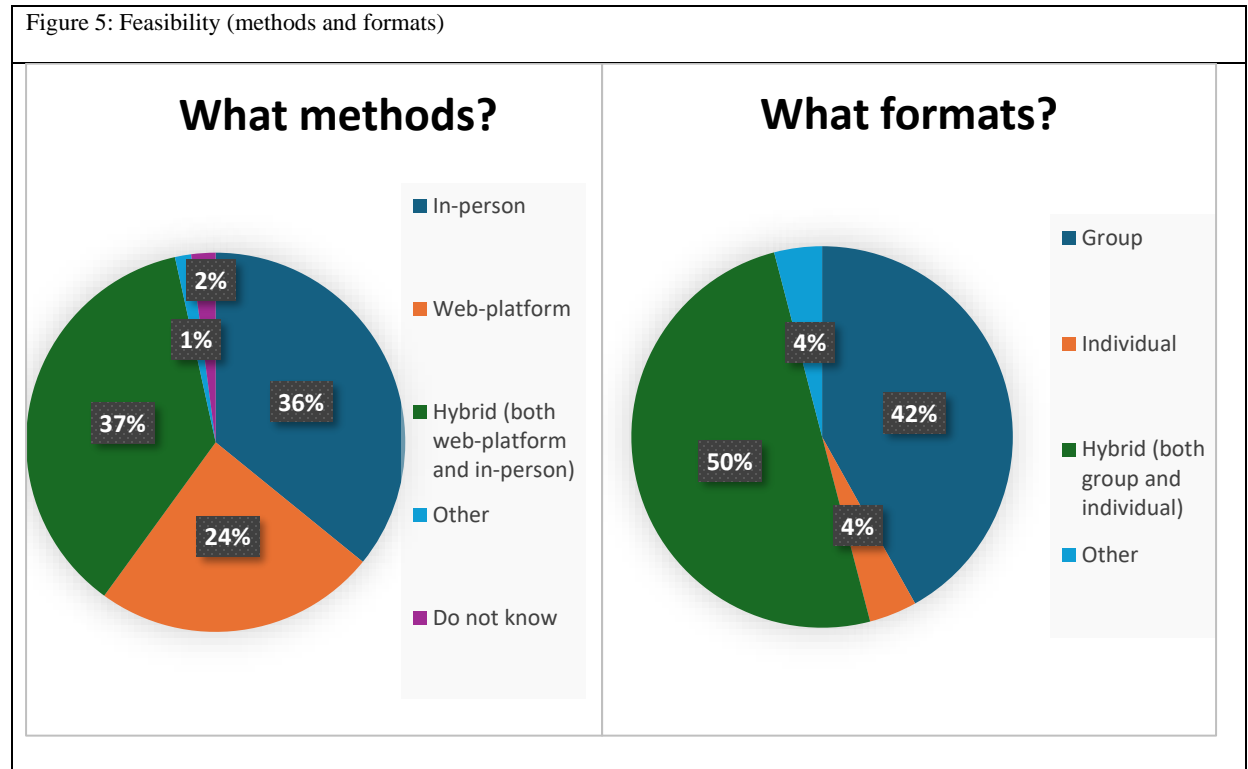
Perceived Feasibility

Delivery Methods and Formats

As shown below in Figure 5, there was roughly equal support for “in-person” (36%) and “hybrid” (i.e., both web-platform and in-person; 37%) methods of intervention delivery, followed by “web-platform” alone (24%). This suggests that survey participants believed some degree of in-person interaction would best support the delivery of *Cultivating Resilience*. This feedback may reflect the various logistical challenges of holding a workshop virtually, coupled with the unique challenges that Latinx communities may encounter with this mode of delivery. For example, participating from one’s own intimate space may inadvertently raise stress or be infeasible due to living conditions or interpersonal dynamics at home. Moreover, virtual methods assume participants not only have technological access, but also the knowledge to navigate required platforms like email and zoom, posing further barriers. Conversely, in-person locations may afford greater privacy, safety, and accessibility for workshop participants.

Half (50%) of survey participants preferred a hybrid format (i.e., both group and individual) for the intervention, followed by group- only (42%). Notably, only 4% endorsed a solely individual format. Thus, a group-based structure was deemed the most feasible for carrying out the intervention. The 4% who endorsed “other” formats essentially provided recommended variations of hybrid delivery. One participant suggested that format should be selected based on the method of delivery, with group formats conducive to in-person delivery and individual formats for virtual methods. Others suggested a predominantly group format, with

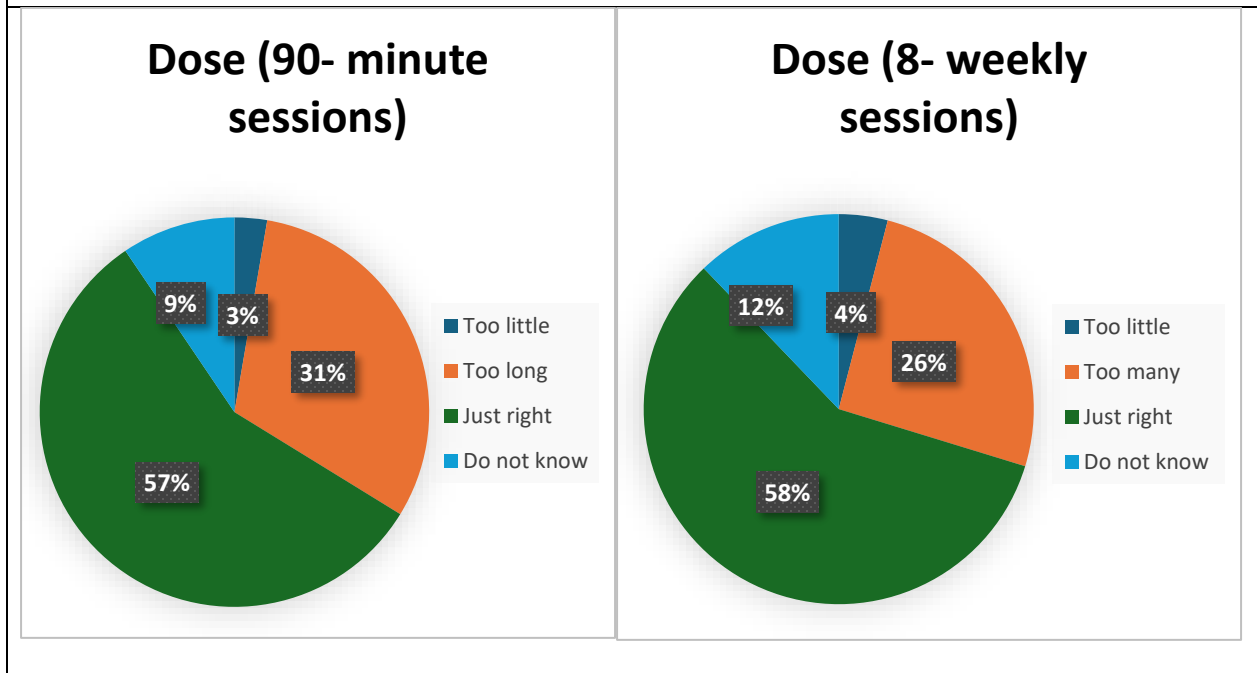
individual check-ins to engage in individualized support for more sensitive topics impacting intervention members.



Dose

As illustrated below in Figure 6, more than half of survey participants considered the “dose” of the intervention (8 weekly, 90-minute sessions) delivered in the RCT to be “just right.” However, 31% found the 90- minute sessions too long, and 26% believed 8 weekly sessions were too many. Only a very small percentage believed 8 weekly, 90-minute sessions were too little (4 and 3%, respectively). Notably, several indicated “do not know,” which may suggest that they felt their expertise was not suited or relevant to judgments on intervention dose.

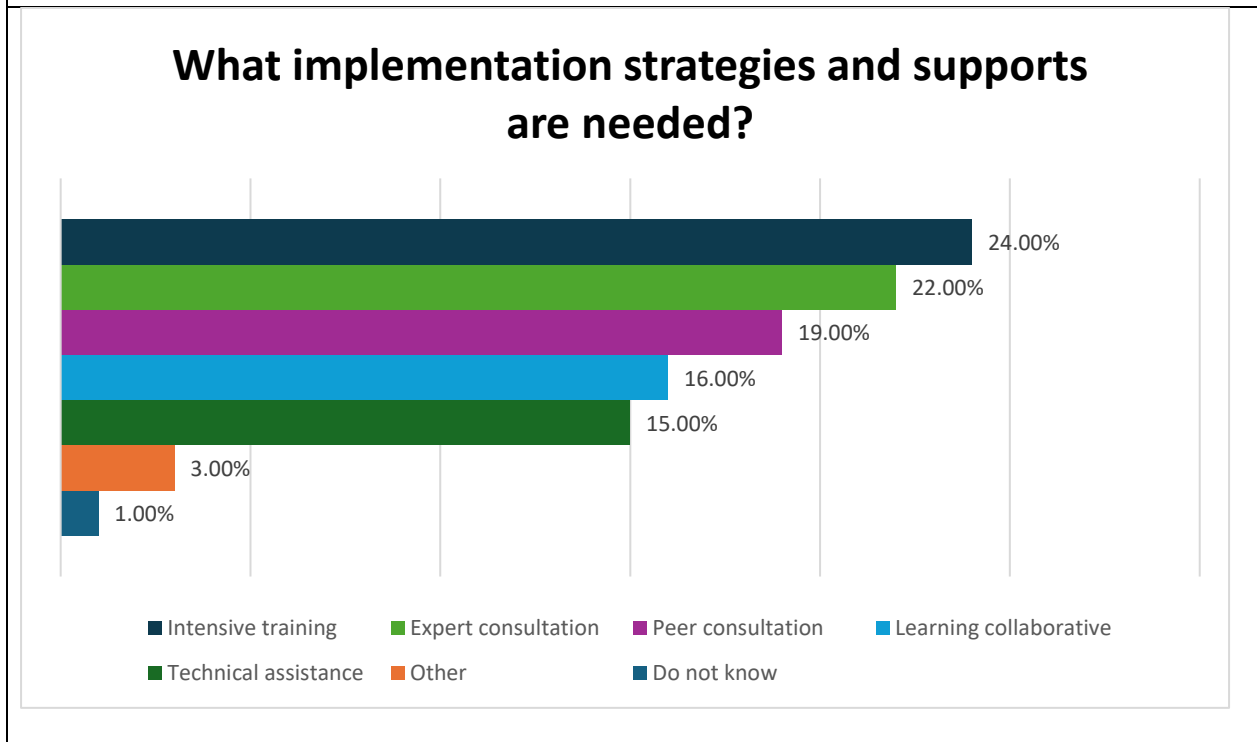
Figure 6: Feasibility (dose)



Implementation Strategies and Supports

As shown below in Figure 7, survey participants believed intervention delivery by non-mental health specialists would be feasible with a wide range of implementation strategies and supports in place. Of all the listed strategies that individuals could select from (categories are not mutually exclusive), intensive training had the highest frequency of responses (24%), followed by expert consultation (22%), peer consultation (19%), learning collaboratives (16%), and technical assistance (15%). Additional strategies were also shared, including “supervision/competency requirements,” “establishing trust and presence a priori,” and “strategies for managing potential mental health crises, potential conflict in group.”

Figure 7: Feasibility (implementation strategies and supports)



Facilitators

As illustrated below in Figure 8, survey participants recognized several professional identities as feasible facilitators of the intervention with appropriate training (categories again are not mutually exclusive) including community health workers (14%), community members who completed the workshop (12%), health care providers/clinicians (12%), public health professionals/health coaches (12%), community advocates/community organizers (12%), employees at community-based organizations (11%), peer specialists (11%), religious leaders (8%), and professors/researchers/academics (7%). They also suggested both bachelor's and graduate level students could be facilitators of the intervention. It is important to note that participants selected community health workers nearly twice as often as professors/researchers/academics. These findings, interpreted alongside the implementation

strategies results, suggest that individuals prefer the intervention be led by community health workers, though this requires intensive training and expert consultation among other supports.

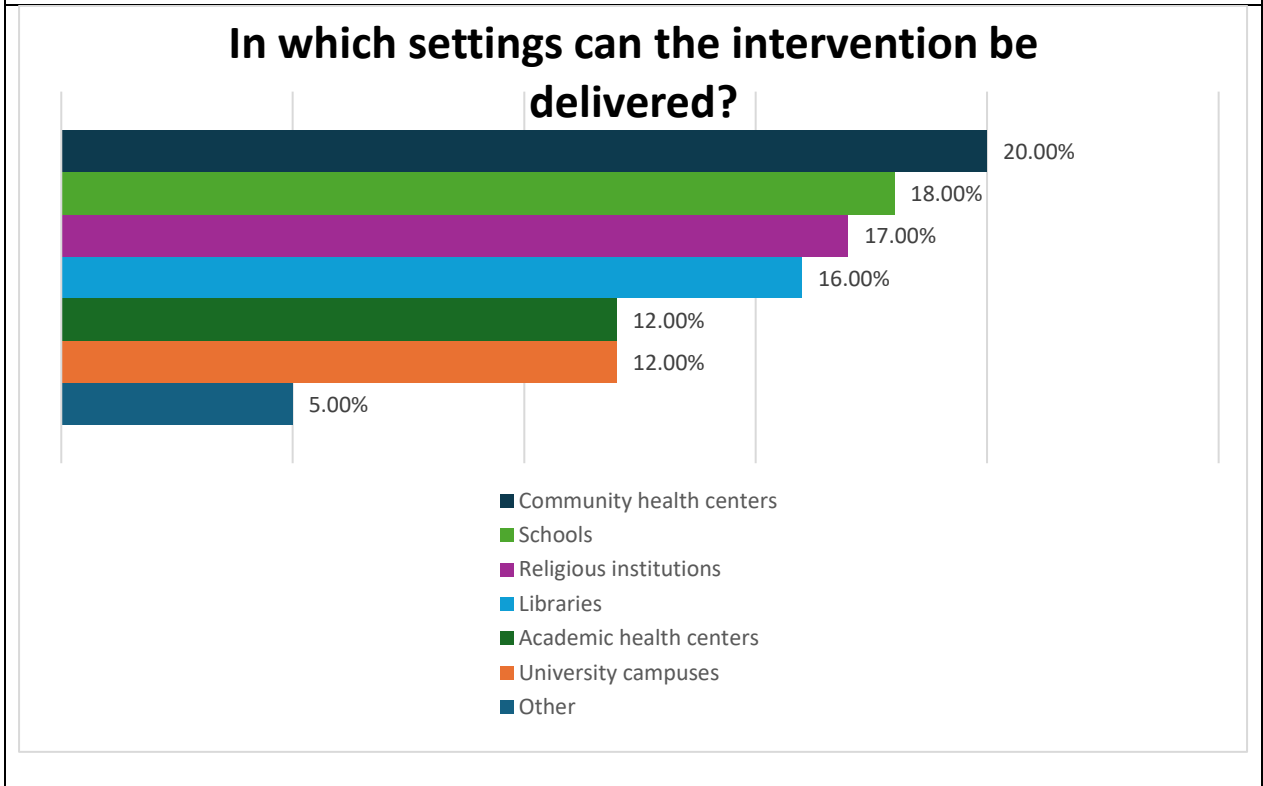
Figure 8: Feasibility (facilitators)



Settings

Survey participants believed the intervention could be delivered across a wide variety of settings (categories are not mutually exclusive) as shown below in Figure 9. The most preferred setting was community health centers (20%), followed by schools (18%), religious institutions (17%), libraries (16%), academic health centers (12%), and university campuses (12%). Other proposed settings included community colleges, primary care clinics, civic centers, parks/green areas, recreational centers, and food pantries. Consistent with the preference for community health workers as facilitators, participants appeared to favor community-based health centers and locations over more academic locations, such as academic health centers and universities.

Figure 9: Feasibility (settings)



Discussion

Throughout the intervention development and refinement phase, it is imperative to draw on community expertise to iteratively evaluate implementation outcomes. These efforts are integral to broader “designing for implementation” principles which function to minimize implementation gaps and help elucidate an intervention’s core (i.e., central) and adaptable (i.e., modifiable) components. However, ongoing assumptions that implementation “comes at the tail end of the pathway from intervention development to evidence” (Chambers et al., 2016) often result in interventions that are not acceptable, appropriate, or feasible for intended communities. Insufficient attention to these implementation outcomes can exert disproportionate harm onto the very communities we are trying to reach by sustaining the research to practice gap, and by extension, health and healthcare inequities.

Within the context of a psychosocial intervention *Cultivating Resilience* comprised of CBT-grounded components, our research team aimed to consider implementation from the outset by compiling quantitative and qualitative perceptions pertaining to its acceptability, appropriateness, and feasibility for Latinx immigrants. To this end, we administered a multimedia survey to a national, multidisciplinary panel of individuals ($N=74$) with experience working in Latinx communities and/or expertise in the field of acculturative stress or implementation science to assess agreement regarding each component’s acceptability (i.e., agreeableness and appeal) and appropriateness (i.e., cultural relevance and suitability). Feasibility questions assessed perceptions of implementability along several delivery factors (i.e., methods, formats, dose, implementation strategies, facilitators, and settings). In line with an explanatory mixed methods (QUAN->qual) design, we held two subsequent focus groups with members of our research team’s Community Advisory Board ($N=10$) to explore component-

specific questions in more depth. Relying on a pillar-building integration process for data analysis, we conducted quantitative analysis (i.e., summary statistics derived from ratings along implementation outcomes) and qualitative analysis (i.e., descriptive thematic analysis extracted from focus groups and open-ended feedback) independently. Analyses were integrated to extract pillar-building themes per component.

Across components, quantitative and qualitative datasets converged on high acceptability and appropriateness, reinforcing the current iteration of *Cultivating Resilience* core components. Mindfulness training was perceived as an acceptable component, with participants generally liking that the practice is actionable and accessible. However, there appeared to be some notable concerns with its cultural appropriateness, which may be most attributable to how the component can be reconciled with a vast heterogeneity in religious beliefs and preferences. Values assessment demonstrated high acceptability, with participants again appreciating the “action” elements within the component (i.e., goal setting). The component also indicated high cultural appropriateness alongside simultaneous beliefs that exploring values may be a culturally unfamiliar or unaddressed concept. Structured problem-solving was deemed highly acceptable, which appeared to reflect perceptions that the component is practical and digestible. The component also exhibited high cultural appropriateness, coupled with recommendations to incorporate more cultural values and elements into its form to optimize appropriateness. Interpersonal skills training showcased high acceptability, with participants appreciating its function in increasing social connection and improving familial functioning. In fact, participants endorsed several aspects of familial interpersonal communication (e.g., negotiation skills) that appeared to be fundamental for the component’s cultural appropriateness. Participants found psychoeducation to be highly acceptable, pointing to its important role in increasing knowledge

acquisition. While the component also demonstrated high cultural appropriateness, targeting knowledge acquisition on topics pertaining to mental health more broadly may optimize its cultural appropriateness. Lastly, connection to community resources indicated high acceptability, with participants appreciating the iterative nature of the component. The cultural appropriateness of this component seemed to be contingent upon how the connection is maintained with ongoing initiative and intentionality. In sum, high ratings of appropriateness across components coincided with feedback to either a) enrich and expand upon existing intervention content by incorporating cultural elements into components or b) modify content by altering the presentation of the component. In this way, findings can be interpreted within the function-form paradigm, whereby our research team can preserve the function of components while optimizing their cultural appropriateness by making functional adaptations to form. To illustrate, our team may explore ways we can preserve the structured problem-solving technique while at the same time incorporating storytelling or musical elements into the component; this adaptation may better facilitate collective healing by allowing individuals to draw upon their unique cultural strengths and roots.

Participants endorsed several demographic adaptations of the intervention to explore age, gender, and language specific topics in greater depth. Additionally, several recommendations were provided for how to better target the male demographic in workshop-based interventions. Feasibility results endorsed the intervention's dose of 8 weekly, 90- minute sessions and indicated support for hybrid methods and formats of delivery. Notably, community health centers and community health workers received the strongest support as possible settings and facilitators, respectively. However, survey participants endorsed a host of other potential facilitators (e.g., community members who completed the workshop, health care providers,

public health professionals, community advocates, employees at community-based organizations, peer- specialists, and to a lesser degree, religious leaders and professors/academics) and potential settings (e.g., schools, religious institutions, libraries, and to a lesser degree, academic health centers and university campuses).

This project has notable strengths. First, the study incorporated both quantitative and qualitative data sources to achieve a cohesive, comprehensive narrative of perceptions about the *Cultivating Resilience* intervention. Just as the intervention itself was developed through bidirectional collaborations with community partners, this sub- study furthers the intervention’s central community-engaged approach by ensuring that feedback from end-users of implementation is prioritized as we further refine *Cultivating Resilience*. We hope that drawing on community voices may in effect bolster the intervention’s streamlining and sustainability to optimize its clinical impact. Therefore, this project can serve as a methodological model that guides future approaches to intervention development and refinement for implementation.

There are important limitations to note. First, our results are a compilation of individual perspectives. In this way, we can speak to trends in conceptualizations of acceptability, appropriateness, and feasibility, but the feedback may not truly identify what is acceptable, appropriate, feasible, or what truly “works” across diverse communities. Second, while our intent in creating survey-embedded videos was to portray the intervention in the most comprehensive and accurate way possible, survey participants’ feedback was fundamentally limited given their limited exposure to the intervention (i.e., they did not directly receive the intervention). In the same way, while focus group participants had foundational knowledge of the intervention as a result of their time serving on our Community Advisory Board and from handouts we distributed during focus groups depicting intervention components, they likewise did not have exposure to

the intervention itself which may have impacted their feedback. Additionally, it is important to note that not all survey participants identified as Latinx immigrants, and therefore although their own unique backgrounds and insights are valuable, they are not considered the intended audience of the intervention itself.

Several future directions are worth considering. As our team proceeds through the intervention refinement phase, we will be triangulating numerous sources of feedback and data in concert to guide meaningful next steps. Specifically, future analyses may draw on the points of convergence and divergence among the feedback provided from *Cultivating Resilience* participants themselves and the present study's participants. For example, in a separate project, we compiled acceptability and feasibility perspectives from individuals who received the intervention, which may counter the current study's feedback on parallel constructs. For instance, whereas individuals who completed the intervention tended to find the dose to be "too little," survey participants found the dose to either be "just right" or "too much/too many." In this example, intervention participants may be speaking from their individual, intimate, and positive experiences with the intervention while participants in the survey may be speaking more so to feasibility concerns (e.g., the sustainability of this dose). Informed by component analysis strategies, future efforts may further attempt to more rigorously pursue mechanistic studies to pinpoint causal mechanisms; relatedly, future studies may explore the additive and interactive effects of the intervention's components to inform how the components operate in conjunction (i.e., rely or build on one another) to produce intervention outcomes.

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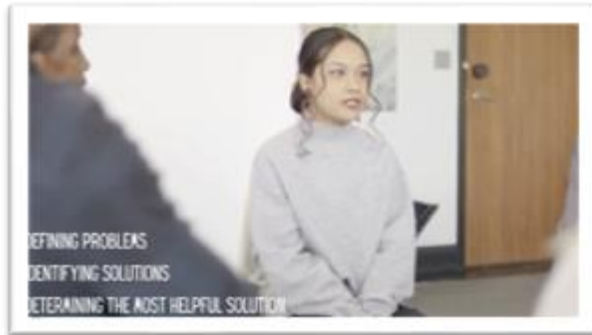
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**Appendix A:
Demographic Questionnaire**

1. What is your age?	
2. Which of the following best describes your professional affiliation? You may select all that apply.	<ul style="list-style-type: none"> a. Professor, researcher, academic, and/or scientist b. Clinician, health care provider, administrator/leader within a health system c. Trainee or student (college, graduate school, medical school, residency, internship, fellowship) d. Community health worker, promotor de salud, peer specialist, lay provider e. Employee at a community-based organization, non-profit agency, 501(c) (3), or governmental agency f. Community advocate, community organizer, community leader, elected leader g. Independent community member (not affiliated with a particular organization) h. Religious leader (e.g., priests, pastors, ministers, deacons, elders, nuns) i. Other _____ j. I do not know k. Prefer not to respond
3. In which geographic region do you currently reside?	<ul style="list-style-type: none"> a. Northwest b. South c. Midwest d. West (inclusive of Pacific Northwest and Mountain West) e. I do not know f. Prefer not to respond
4. With which gender do you identify?	<ul style="list-style-type: none"> a. Man b. Woman c. Trans Woman d. Trans Man e. Agender or Gender Non-Binary f. Another Gender Not Listed Here _____ g. I do not know h. Prefer not to respond
5. With what race(s) do you identify? You may select as many that apply.	<ul style="list-style-type: none"> a. American Indian or Alaska Native b. Asian c. Black or African American d. Multiracial e. Native Hawaiian or Other Pacific Islander f. White g. Another race not listed here _____ h. I do not know i. Prefer not to respond
6. Do you identify as Hispanic, Latino, Latina, Latine, Latinx, or Latin American?	<ul style="list-style-type: none"> a. Yes b. No c. I do not know d. Prefer not to respond

<p>7. In what ways have you worked with the Latino/Hispanic community?</p>	<hr/>
<p>8. What is the highest degree or level of education that you have completed?</p>	<ul style="list-style-type: none"> a. Less than high school b. High school degree or equivalent (GED) c. Some college d. Associates degree or trade school e. Bachelor's degree f. Master's Degree g. Graduate/PhD/MD h. I do not know i. Prefer not to respond

Appendix B: Sample Snapshots of Multimedia Videos



**Appendix C:
Survey Implementation Outcome Questions**

After viewing the video, please express the extent to which you believe the [x] component:	
1. Is agreeable and appealing	<ol style="list-style-type: none"> 1. Strongly disagree 2. Disagree 3. Neither disagree nor agree 4. Agree 5. Strongly agree
2. Acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second-generation Latinxs/Hispanics	<ol style="list-style-type: none"> 1. Strongly disagree 2. Disagree 3. Neither disagree nor agree 4. Agree 5. Strongly agree
3. Adequately addresses the topic of acculturative stress experienced by first- and second- generation Latinxs/Hispanics.	<ol style="list-style-type: none"> 1. Strongly disagree 2. Disagree 3. Neither disagree nor agree 4. Agree 5. Strongly agree
4. Holds the potential to have a positive health impact by reducing acculturative stress experienced by first- and second- generation Latinxs/Hispanics.	<ol style="list-style-type: none"> 1. Strongly disagree 2. Disagree 3. Neither disagree nor agree 4. Agree 5. Strongly agree
5. Do you have any other feedback or thoughts pertaining to how this component is integrated into the workshop or additional therapeutic strategies?	<hr/> <hr/>
6. The current pilot RCT of “Cultivating Resilience” is being delivered by bilingual, bicultural psychologists. With appropriate training, who do you think could be appropriate facilitators of this program? Please select all that apply.	<ol style="list-style-type: none"> a. Health care providers or clinicians (e.g., clinical social workers, master’s-level clinicians, psychiatrists, psychiatric nurse practitioners) b. Community health workers, promotores de salud c. Peer-specialists (i.e., individuals with lived mental health experience) d. Community members who have participated/graduated from the group e. Public health professionals, health coaches, lifestyle coaches f. Religious leaders (e.g., priests, pastors, ministers, deacons, elders, nuns) g. Professors, researchers, academics, scientists h. Employee at a community-based organization, non-profit agency, 501(c) (3), or i. governmental agency j. Community advocates, community organizers, community leaders, elected leaders k. Other: _____ l. I do not know m. Prefer to not respond
7. What are the settings that you think this intervention could be delivered in? Please select all that apply.	<ol style="list-style-type: none"> a. Religious institutions (e.g., churches, temples, etc.) b. Schools (i.e., parent group while children attend school or after-school program) c. Community health center d. Academic health center e. Libraries f. University campuses g. Other: _____ h. I do not know i. Prefer to not respond

<p>8. Currently, this program is being offered to individuals who meet the following criteria:</p> <ul style="list-style-type: none"> • over age of 18; • self-identify as Latino/a/e/x or Hispanic; and • speak conversation Spanish (as the group sessions are conducted in Spanish). <p>Additionally, in the pilot RCT, we are allowing both immigrants and refugees (born outside of the US) as well as US-born individuals (e.g., born to immigrant parents).</p> <p>We are not restricting enrollment to individuals based on their level of acculturative stress (i.e., individuals with any level of acculturative stress are allowed to participate).</p> <p>We are allowing individuals to participate regardless of the presence of a mental health concern or the extent to which they are currently receiving treatment (i.e., we did not exclude individuals with psychopathology).</p> <p>As we move forward in continuing to offer this group to Latinxs/Hispanics, are there any considerations that we should have related to the eligibility criteria?</p>	
<p>9. This workshop is offered both in-person and virtually through a web platform. What methods do you think would work well to offer this workshop in the future? Please select all that apply.</p>	<ul style="list-style-type: none"> a. Web-platform b. In-person c. Hybrid (both web-platform and in-person) d. Other: _____ e. I do not know f. Prefer to not respond
<p>10. Participants are to receive this workshop in a group format. In the future, do you believe this workshop should be delivered in a group format, individual format, a combination of both group and individual format, or another format?</p>	<ul style="list-style-type: none"> a. Group b. Individual c. Both (Combination) d. Other: _____ e. I do not know f. Prefer to not respond
<p>11. Each session of this workshop lasts ninety (90) minutes. Do you think this length is too little, just right, or too long?</p>	<ul style="list-style-type: none"> a. Too little b. Just right c. Too long d. I do not know e. Prefer to not respond
<p>12. This workshop comprises eight (8) sessions that occur weekly. Do you think the number of sessions in this workshop is too little, just right, or too many?</p>	<ul style="list-style-type: none"> a. Too little b. Just right c. Too many d. I do not know e. Prefer to not respond
<p>13. If this intervention were to be delivered by non-mental health specialists, what kinds of supports would need to be put in place for them to optimally deliver the intervention? Please select all that apply.</p>	<ul style="list-style-type: none"> a. Intensive training b. Learning collaborative c. Peer consultation d. Expert consultation e. Technical assistance f. Other: _____ g. I do not know h. Prefer to not respond

**Appendix D:
English Semi-Structured Focus Group Guide (Focus Group 1)**

ACTIVITY EXPLORING THEMES OBSERVED IN RESULTS:

1. Mindfulness Exercise

We received feedback that mindfulness may appear too Americanized and that it is important to incorporate cultural elements into mindfulness practice. In what ways could this practice be tailored or contextualized to better reflect Latino values and culture?

2. Values Assessment

We received feedback to re-evaluate the word and concept of “values” itself as presented in the intervention. What are your thoughts pertaining to “valores” and how it should be presented throughout the intervention to appropriately reflect Latino beliefs and culture?

3. Structured Problem Solving

We received feedback that the structured problem-solving process may follow a linear approach for navigating problems that may not resonate with all Latinos. In what ways can this process be adapted to reflect cultural norms for problem-solving?

4. Feasibility Considerations

There were suggestions to offer variations of the intervention specific to age group (adolescents/young adults/older adults), generational status (first- generation/second-generation), sex (men/women), and language (Spanish only/English only/ Bilingual). What are your comments or concerns about any of these potential adaptations?

**Appendix E:
Spanish Semi-Structured Focus Group Guide (Focus Group 1)**

ACTIVIDAD PARA EXPLORAR LOS TEMAS OBSERVADOS EN LOS RESULTADOS:

1. Ejercicio de atención plena

Recibimos comentarios sobre la actividad de atención plena que parece ser muy americanizada y que es importante incorporar elementos culturales en la práctica de atención plena. ¿En qué manera esta práctica puede ser adaptada o contextualizada para mejorar como los valores y la cultura latina son reflejados en esta?

2. Evaluación de valores

Recibimos retroalimentación sobre reevaluar el concepto y la palabra “valores” tal como está presentada en el taller. ¿Cuál es su opinión en respecto a la palabra “valores” y como debe de ser representada durante el taller para que refleje de manera apropiada las creencias y cultura latina?

3. Resolución de problemas de forma estructurada

Recibimos retroalimentación sobre el proceso de resolución de problemas de forma estructurada puede seguir un enfoque lineal para lidiar los problemas. Es posible que latinos no conozcan esta estrategia para resolver problemas cotidianos. ¿En qué maneras se puede utilizar este proceso para reflejar los aspectos culturales para resolver problemas?

4. Consideraciones factibles

Hubo sugerencias para ofrecer variaciones del taller para edades específicas (adolescentes/jóvenes adultos/adultos mayores), tipo de generación (primera generación/segunda generación), sexo (hombres/mujeres) e idioma (sólo inglés/sólo español/bilingüe) ¿Cuáles son sus comentarios o preocupaciones sobre estas posibles adaptaciones?

**Appendix F:
English Semi-Structured Focus Group Guide (Focus Group 2)**

1. Interpersonal Communication Training

Sometimes cultural and family values can be in conflict with individual values. As ways to improve interpersonal communication are discussed in the workshop, how can cultural and family values be balanced with individual goals and values?

2. Psychoeducation (information about health)

Cultivating resilience is a workshop for the promotion of mental health, but it is not psychotherapy. In the workshop we focus on stress management, which can be related to mental health, but we do not delve into the topic of mental health specifically. However, many of our participants know that they are struggling with mental health issues and also mention this within the group. In the context of an intervention based in prevention and promotion, to what extent should we address mental health issues?

3. Connection to community resources

Part of the workshop focuses on connecting participants with community resources in different areas – physical and mental health, classes/education, legal, family help, violence prevention, etc. Unfortunately, sometimes resources are overwhelmed, or participants have a hard time connecting with those resources. How can we improve the connection between those resources and participants?

**Appendix G:
Spanish Semi-Structured Focus Group Guide (Focus Group 2)**

1. Entrenamiento de comunicación interpersonal

A veces los valores culturales y familiares pueden estar en conflicto con los de uno como individuo. En medida que se discuten maneras de mejorar la comunicación interpersonal en el taller, ¿cómo se puede balancear los valores culturales y familiares con las metas y los valores individuales?

2. Información sobre la salud

Cultivando Fortaleza es un taller para la promoción de la salud mental, pero no es psicoterapia. En el taller nos enfocamos en el manejo de estrés, que puede estar relacionado con la salud mental, pero no profundizamos en el tema de la salud mental en específico. Sin embargo, muchos de nuestros participantes saben que están luchando con problemas de salud mental y también lo mencionan dentro del grupo. En el contexto de una intervención de prevención y promoción, ¿en qué medida debemos abordar temas de la salud mental?

3. Conexión a recursos comunitarios

Parte del taller se enfoca en conectar a los participantes con recursos comunitarios en distintas áreas – salud física y mental, clases/educación, legal, ayuda familiar, prevención de violencia, etc. Desafortunadamente, a veces los recursos están saturados o los participantes tienen muchas dificultades para conectar con esos recursos. ¿En qué manera podemos mejorar la conexión entre esos recursos y los participantes?

Appendix H: Qualitative Codebook

Domains	Questions asked in CAB meeting/s/survey	Categories	Codes	Sub-codes	Definitions
Mindfulness Training	**CAB: <i>We received feedback that mindfulness may appear too Americanized and that it is important to incorporate cultural elements into mindfulness practice. In what ways could this practice be tailored or contextualized to better reflect Latino values and culture?</i>	The cultural appropriateness (i.e., cultural relevance, suitability, fit, usefulness) of mindfulness training is dependent on several contextual factors	--	--	Participants recognized several factors that will modulate how culturally relevant and suitable mindfulness is for Latino populations.
			Generational differences	--	Participants pointed to generational differences (i.e., variation attributed to age) in the adoption of mindfulness, which may impact the exercise's cultural appropriateness.
				Younger generations are more familiar with the practice	Participants expressed how mindfulness strategies are considered new to the Latino community, with younger generations having more familiarity and experience with the practice. Conversely, for older generations of Latinos, the practice may not be as culturally relevant.
			Vast heterogeneity in religious affiliations and preferences	--	Participant feedback demonstrated the importance of recognizing how diverse religious identities in the community will impact the cultural appropriateness of mindfulness.
				For the component to be culturally appropriate, a stronger connection between mindfulness and cultural religious components (i.e., prayer) is needed	Some participants suggested that mindfulness should be adapted to incorporate links to religion in order to improve the component's cultural appropriateness.

	<p>**SURVEY: Do you have any other feedback or thoughts pertaining to how this component is integrated into the workshop?</p>			<p>The component is inherently not culturally appropriate because it is incompatible with cultural religious practices & identities</p>	<p>Some participants suggested that mindfulness as a component is fundamentally not culturally appropriate and does not need to be adapted but rather eliminated and/or replaced by religious components.</p>		
				<p>The component is culturally appropriate if it continues to be taught neutrally, void of any religious attributions /associations</p>	<p>Some participants emphasized the importance of the approach (i.e., manner) in which mindfulness is presented in the workshop. Specifically, while they acknowledged that mindfulness may carry sociocultural and religious origins, they endorsed a neutral (i.e., more generalized) approach to respect participants' individual beliefs. By keeping the focus solely on the practice, it will be respectful of all religious affiliations.</p>		
				<p>--</p>	<p>Participants acknowledged that the language used to describe/teach mindfulness is meaningful. They suggested that we explore different terms that may resonate more with Latinos.</p>		
				<p>Some will be more responsive to language "Relaxation" or "calm down"</p>	<p>Relaxation ("tranquilizar") as an alternative term was proposed. Closely related with mindfulness, relaxation is commonly defined as calming the body and mind.</p>		
				<p>Some will be more responsive to language "Meditation"</p>	<p>Meditation ("meditar") as an alternative term was proposed. Closely related to mindfulness, meditation is commonly defined as a specific method/practice with a focus on training attention and concentration.</p>		
				<p>Some will be more responsive to language "Be conscious"</p>	<p>Be conscious or live consciously ("ser conciente") as an alternative term was proposed. Closely related to mindfulness, to live consciously is commonly defined as grounding one's thoughts and feelings to the present moment, not the past or future.</p>		
				<p>Fit between terminology "mindfulness" and target population (consider alternate terminology)</p>			

				Some will be more responsive to a focus on "emotional intelligence"	A focus on emotional intelligence as an alternative word/concept was proposed. Sometimes evaluated as a byproduct or correlate of engaging in mindfulness, emotional intelligence is commonly defined as the ability to identify and manage one's own emotions as well as those of others.
			Experiences with/of acculturative stress	--	Participants noted that the cultural appropriateness of mindfulness may depend on a recognition of experiences with/of acculturative stress within the component.
		Mindfulness training is an acceptable (i.e., adequate, appealing agreeable, satisfactory) component	--	--	Participants generally endorsed mindfulness training as a component in the intervention, noting several qualities of the exercise which are appealing.
			Participants liked that the practice is actionable (i.e., is a concrete skill to practice)	--	Participants specifically appreciated how mindfulness is an "action" component, meaning that it moves from awareness and knowledge acquisition to a skill individuals can engage in/enact in their lives.
			Participants liked that the practice is easily accessible	--	Participants liked that mindfulness is something individuals can readily access (i.e., apply, use, interact with) in their daily lives. It is not resource or time intensive.

			Participants liked the practice's subcomponent of gratitude	--	Participants particularly appreciated that one of the key tenets of this component is gratitude (i.e., giving thanks for certain things or people), endorsing this exercise as an agreeable activity.
Values Assessment	**CAB: <i>We received feedback to re-evaluate the word and concept of "values" itself as presented in the intervention. What are your thoughts on values and how it should be presented through the intervention to appropriately reflect Latino beliefs and culture?</i> **SURVEY: <i>Do you have any other feedback or thoughts pertaining to how this component is</i>	Suggestions to optimize the cultural appropriateness of values assessment	--	--	There were several suggestions for how the values assessment component could be more in-line with Latino culture and perspectives.
			Group members may not identify with the word "valores." Consider alternative terminology to describe and contextualize the concept for the community	--	Participants pointed out that the word may need to be elaborated upon, especially given its unfamiliarity and different meaning across contexts. Participants pointed out this is particularly important given that values, like other mental health topics, historically have not been discussed in the Latino community and so it is important to have patience and contextualize the concept. CAB Members suggested contextualizing the concept of values (i.e., via different potential descriptors) to help participants understand the process of values assessment.
				Present as "ways of living" or "family rules"	Members suggested describing values as one's own way of living ("manera de vivir") or own family's rules ("reglas de vivir para la familia").
				Present as "introspective thinking" / "internal processing" / "beliefs"	Members suggested using terms like introspective thinking, internal processing, and beliefs, which convey values as intimate to the inward self.
				Present as "virtue"	When discussing personality traits, it was recommended to use the word virtue ("virtud"), which refer to specific qualities of individuals.
			Values are inherently personal/intimate; therefore emphasize group norms before values activities	--	Participants endorsed the idea that particularly in Latino culture, values are often rooted in familism, and thus are very intimate (i.e., personal), which can lead to potential debate/conflict if one's own values do not align with another's, especially in the context of group discourse centered on values. Therefore, to ensure values assessment activities respect group differences, participants suggested reiterating group norms (i.e., shared expectations and standards) prior to engaging in conversations regarding values.

	<i>integrated into the workshop?</i>			No giving advice ("consejos")	Participants specifically endorsed a group norm of not giving advice to other group members within the scope of conversations related to values (i.e., not imposing values on one another).		
				No judging	Participants suggested a group norm of no judging others during conversations about values (i.e., not criticizing or negatively analyzing the values that others identify with).		
				Listen while others are speaking	Participants agreed on a group norm that reminds participants to listen while others are speaking (i.e., not interjecting or interrupting while other participants are sharing their thoughts).		
				Expand on workshop content that emphasizes the difficulties in value-aligned behavior amid uncontrollable stressors	--	Participants were in support of making sure there is substantial time allotted to recognizing and validating the complexities of pursuing value-aligned lives in the face of uncontrollable stressors and acculturative stress. Part of this recommendation included adopting an inductive approach.	
					Values assessment is an acceptable component	--	Values assessment was deemed an adequate and important component to be taught/discussed with Latinos in the workshop.
						Participants liked the "action" element (goal setting)	--
Structured Problem-Solving	**CAB: <i>We received feedback that the structured problem-solving process</i>	Considerations for ensuring cultural appropriateness of structure	--	--	Participants shared different perspectives on the structured problem-solving process and the sorts of factors to consider in order to ensure and enhance the skill's cultural appropriateness for Latinos. Specifically, their considerations are rooted in perceptions that the practice may not be culturally relevant for how Latinos engage in problem solving and may not be culturally useful for navigating the types of problems prevalent in the community.		

<p><i>may follow a linear approach for navigating problems that may not resonate with all Latinos. In what ways can this process be adapted to reflect cultural norms for problem-solving? **SURVEY: Do you have any other feedback or thoughts pertaining to how this component is integrated into the workshop?</i></p>	<p>red problem-solving</p>	<p>The practice may not be natural for Latinos; consider incorporating more flexibility</p>	--	<p>Participants acknowledged that many in the community may not process their thoughts in the sort of sequential manner that the structured problem-solving process offers.</p>
		<p>The practice cannot always serve more complex, structural problems; provide resources and validation accordingly</p>	--	<p>Participants underscored the prevalence of larger societal, structural problems that Latinos face which may make it difficult for participants to navigate their problems through the structured problem-solving steps. Participants therefore emphasized the need of our team to stress that we are not suggesting that this sort of problem-solving process can solve more structural problems, and to always have resources available when group members bring up more complex needs.</p>
		<p>The individual focus of the practice may not resonate with Latino values; incorporate group-based problem-solving</p>	--	<p>Participants highlighted how many in Latino communities rely on others within their social networks to solve problems. Some therefore suggested our team address/include the role of the group within this component.</p>
		<p>For some, engaging with story or visual representations of the skill would enhance utility/application</p>	<p>Upon perceiving that the structured problem-solving process may not be suitable for the cultural diversity in problem solving approaches, participants suggested enhancing the comprehension and application of the skill by incorporating a form of interactive, visual, or story-telling element.</p>	

		Structu red proble m solving is an accepta ble compon ent	--	--	Participants shared different perspectives on the linear approach (i.e., formula) of problem-solving used in the workshop. While CAB members pointed to the ways the practice may not be initially perceived as culturally appropriate, they nonetheless endorsed this formulaic process and were strong proponents of it continuing to be taught as such in the workshop.
			Participan ts liked that the practice is didactic	--	Participants appreciated the structured problem-solving formula, regarding it as well-presented and informative.
			Participan ts liked that the practice is simple/un derstanda ble	--	Participants appreciated how the structured problem-solving formula is easy to follow and comprehend.
Adaptation Considerations	**CAB: <i>There were suggestions to offer variations of the intervention specific to age group (adolescents/young adults/older adults), generational status (first-generation/second-</i>	The worksho p should be adapte d for differen t demogr aphic groups	--	--	Participants endorsed several different adaptations for specific demographic groups that they believe should be offered. They highlighted the importance of respecting the unique culture and context of these individual groups by adapting material in ways that honor group differences.
			Groups for those who identify as LGBTQIA	--	Participants endorsed offering the workshop specifically for individuals who identify as LGBTQIA and adapting material to address this population's unique stressors/mental health.
			Groups for men only	--	Despite learning of the current low enrollment of men in the workshops offered thus far, participants nonetheless endorsed the idea of offering men-only groups of the workshop and not stopping efforts to do so even in the face of challenges.
				Consider younger men generations	Participants recommended the value of targeting younger male generations (i.e., high school or college aged) in particular for these groups, as their willingness to participate may be higher.
			--		

<p><i>generation), sex (men/women), and language (Spanish only/English only/Bilingual). What are your comments or concerns about any of these potential adaptations? **Prompt/follow-up comment: We have also received recommendations to offer the workshop tailored specifically for couples ("parejas"). Thoughts?</i></p>		Groups based on age		Participants were in favor of offering different groups specific to age category; for example, CAB participants shared how younger-generation groups may find it useful to share their pronouns, but that practice is not as relevant or wanted among older generations. More generally, participants endorsed this idea as it would allow groups to explore more age-focused topics.
		Groups based on generational status	--	Participants endorsed the idea of adapting the intervention for groups based on generational status (i.e., first-generation vs. second-generation Latino immigrants)
		Groups based on language proficiencies and preferences	--	Participants endorsed the idea of offering the intervention for different groups based on language preferences of those enrolling. For example, there were suggestions to offer English-speaking groups and bilingual groups in addition to Spanish-speaking groups.
	The workshop should not be adapted for certain demographic groups	--	--	CAB participants noted that when exploring possible adaptations, some adaptations should be avoided.
		Groups for couples only	--	The facilitator prompted CAB participants to consider the possibility of adapting/offering the workshop for couples only. CAB members generally did not approve of this adaptation idea, saying that couples-based intervention should be within the space of formal therapy services.
			Recognition of high rates of DV in Latino populations	With respect to the idea of adapting Cultivating Resilience as a couples focused intervention, CAB participants noted this could be both challenging and even damaging to roll out given high rates of intimate partner violence in Latino communities.
	Strategies to overcome challenges with men enrollment	--	--	CAB participants noted likely challenges with trying to implement men only groups; they emphasized how there are inherent challenges with recruiting men for workshops where they have to discuss their feelings, a deep-rooted cultural problem that is hard to solve. CAB participants offered several recommendations for how we can better target the male demographic for the workshop, and therefore increase enrollment numbers of men.
		Employ targeted marketing	--	CAB participants suggested we could adapt workshop materials (e.g., recruitment flyers, descriptions, etc.) themselves in ways that cater to men.

			towards men	Place "men" before "women" in workshop materials	CAB participants suggested we could modify our recruitment materials linguistically, placing an emphasis on "men" before "women."	
				Distance from "feminine" descriptions of workshop	CAB participants suggested that connotations associated with words have power and that even the word workshop ("taller") has a feminine connotation that equates to emotions; they discussed the utility of using different words to describe the workshop that camouflage the idea of talking about emotions/feelings.	
				Frame the workshop in ways that reflect male cultural roles/values/ interests	CAB participants advocated for different ways we can meet men where they are; they suggested motivating men to participate in the workshop by framing the material as tools to increase their capacity in their roles as "head of the household;" offering the workshop in traditionally male settings (e.g., involving sports, the outdoors, more neutral locations).	
			Build a culture of empowering male vulnerability	--	CAB participants spoke to the significance of broader efforts to empower men vulnerability, teaching them to share their emotions and creating safe spaces for them to do so.	
Interpersonal Skills Training	**CAB: <i>As ways to improve interpersonal communication are discussed in the workshop, how can cultural and family values be balanced with individual goals and values?</i> **SURVEY: <i>Do you have</i>	The cultural nuances of family relations are fundamental to the cultural appropriateness of this component	--	--	Participants emphasized that efforts to improve the cultural appropriateness of interpersonal skills training must center cultural considerations related to Latino familial values and communication.	
			Emphasize the role of respectful balance/negotiation within the familial unit	--	--	Participants underlined that workshop content related to interpersonal skills training should tie in the role of pursuing balance and negotiation within the family in a healthy, respectful manner.
				Balance/negotiation of parental permissibility (flexibility) and authority (e.g., saying no)	Specifically, participants noted the importance of balance and negotiation within parent-child relationships. Participants underscored the value of finding the balance between being flexible with their children (e.g., avoiding sayings like "this is my house, my rules.") and at the same time setting boundaries and limits as leaders within the home. This form of balance/negotiation should be addressed in the workshop.	

	<i>any other feedback or thoughts pertaining to how this component is integrated into the workshop?</i>			Balance/negotiation of familial or societal values and individualism (e.g., individual values)	Participants highlighted the importance of balancing/negotiating familial values and individual values. They described how children in particular tend to have individual goals and it is important that parents allow space for children to forge their own personal identities; however, these may conflict with familial values and so it is valuable for the workshop to address the role of interpersonal communication in navigating such conflicts. Participants also recognized that values are inherently grounded in cultural traditions/patterns, some of which may be deemed problematic at the individual level (e.g., machismo). Therefore, inherent to this component is negotiating within the family which familial/societal values should be challenged versus those which should be preserved.	
				Balance/negotiation related to biculturalism	Participants suggested emphasizing the role of interpersonal skills training in negotiating biculturalism within the family. Participants discussed how this is particularly important given that children and adolescents tend to be more exposed to different cultures outside of the home which can lead to important, challenging conversations within the family about children exploring assimilation while also preserving their homeland heritage.	
			Validate that the contexts and conditions in which families live can make interpersonal communication difficult	--	Participants noted that when living in poverty, parents may struggle to regulate and communicate their emotions in healthy ways with their families and children.	
				--	There was a general consensus among participants that interpersonal skills training is an agreeable and satisfactory component in the workshop.	
		Interpersonal skills training is an acceptable component		--	Participants liked that the skill aims to foster social connectedness	Participants shared that they specifically appreciated this component's target (i.e., purported mechanism) of social connectedness.
				--		

			Participants liked that the skill already addresses familial relationships	--	Participants also appreciated that the component demonstrates elements related to family communication and relationships.
Psychoeducation	<p>**CAB: <i>In the context of an intervention based in prevention and promotion, to what extent should we address mental health issues?</i></p> <p>**SURV <i>EY: Do you have any other feedback or thoughts pertaining to how this component is integrated into the workshop?</i></p>	It is culturally appropriate to provide education about mental health issues/topics in the workshop	Incorporate information about different dimensions of mental health into workshop sessions	--	Participants emphasized that when engaging with Latino communities, it is important we do not assume that the community is familiarized with foundational knowledge about mental health topics like depression and stress. For that reason, participants believed it is culturally relevant and useful to have space within the workshop addressing mental health themes.
				--	Participants suggested several different components of mental health that we should consider adding to workshop sessions.
				Therapy for mental health (including distinction between therapy and a workshop)	Participants noted the utility of including information in workshop sessions that discuss what therapy is, its benefits, and when it may be more useful to pursue therapy for mental health concerns rather than participating in a preventative workshop alone.
				De-stigmatizing mental health	Participants suggested that we teach group members the importance and value of discussing mental health, paying particular attention to removing the stigma associated with the topic. Participants noted this is especially important given that mental health topics are often received with stigma and shame in Latinx communities.
				Mental health causes and triggers	Participants suggested we incorporate information related to certain causes and triggers associated with mental health struggles, including how to identify them in their own lives.
				Mental health prevention and early detection	Participants endorsed the idea that it is key to keep the intervention within the realm of prevention (e.g., teaching groups members steps they can take to take of their minds and bodies to prevent issues from arising/growing).
				Mental health symptoms	Participants suggested it would be valuable to include relevant information pertaining to specific symptoms group members may be encountering (e.g., physical and/or mental indications of mental health issues).
				Help-seeking awareness and promotion	Participants suggested that given cultural patterns of not seeking treatment, the workshop should not only teach about the identification of triggers, preventative steps, and symptoms, but also teach how individuals can recognize they

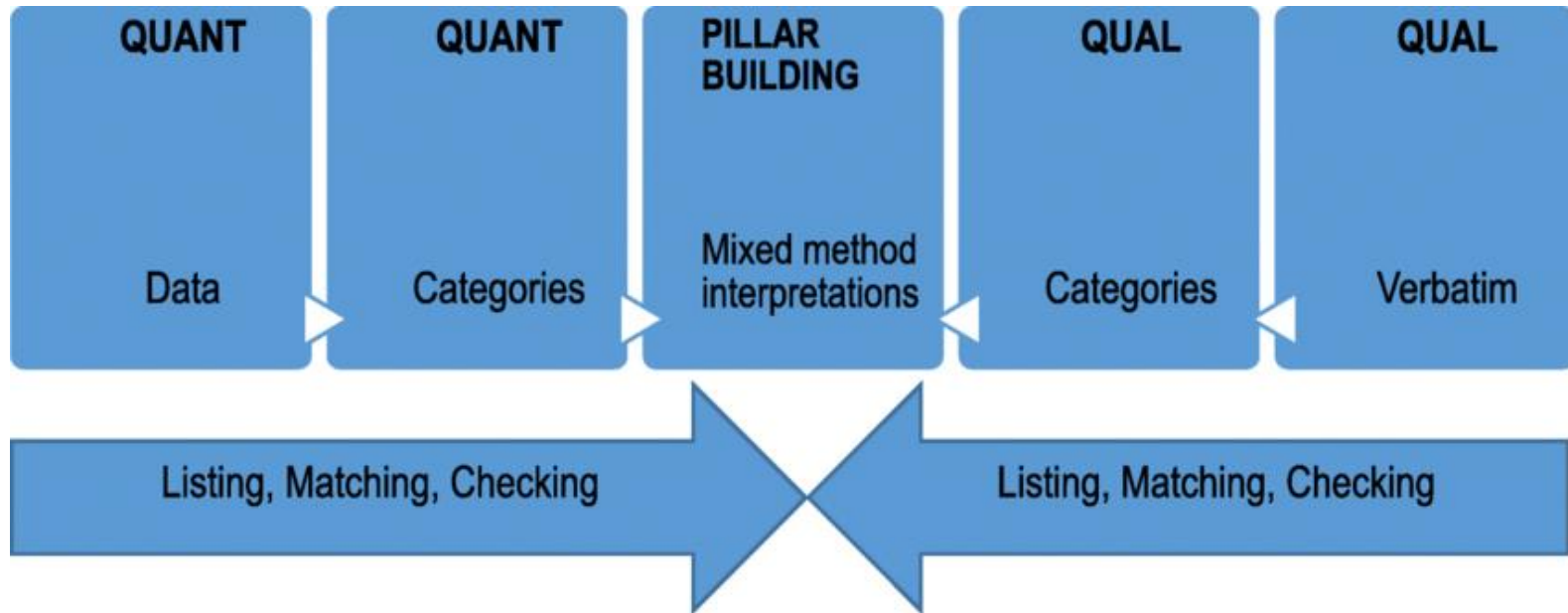
					need help and how they can navigate seeking help when needed. For some, this may mean seeking more workshop-focused intervention, while for others this may mean pursuing formal mental health services (e.g., therapy). For others, this may mean leaning on their faith.
				The role of social drivers (e.g., racism) in exacerbating mental health issues	Participants highlighted the value of incorporating information underscoring that social drivers, such as racism and being marginalized, have an instrumental impact on one's wellbeing, stress, etc.
			Assess the level of risk among group members to inform tailored informational supports and resources	--	Participants suggested that in addition to providing information related to general mental health themes, it would also be appropriate to gauge the sorts of mental health concerns group members are entering the workshop with, in order to meet their unique mental health needs.
				Ask targeted questions to group members to screen for mental health symptoms and risk	Participants suggested having a sort of informal "diagnostic" process screening for mental health concerns (e.g., by asking questions related to their sleep habits/quality, their relationships with their children/family, etc.)
		Psycho education is an acceptable component	--	--	Participants generally endorsed this component as agreeable, satisfactory, and adequate.
			Participants liked that the component aims to increase understanding and knowledge	--	Participants specifically recognized that this component is agreeable in that it targets knowledge acquisition, which in itself can make group members feel more validated and empowered.
Connection to Community Resources	**CAB: <i>Unfortunately, sometimes resources are overwhelming, or participants have a hard</i>	Intentionality and initiative are integral to the cultural appropriateness of the	--	--	Participants recognized several ways to improve the cultural relevance and usefulness of the connection to community resources component. All these suggestions imply that our team's approach must be rooted in intentionality and a constant willingness to go above and beyond to identify and expand the availability of resources for the community.
			Provide more resources	--	Participants communicated the importance of our team partaking in iterative efforts to search for and provide more accessible resources to workshop participants.

<p><i>time connecting with those resources. How can we improve the connection between those resources and participants?</i></p> <p>**SURVEY: <i>Do you have any other feedback or thoughts pertaining to how this component is integrated into the workshop?</i></p>	<p>connection between workshop participants and community resources</p>		Look into offering more resources outside of Milwaukee	Specifically, participants suggested that our team take the initiative to explore resources that may be further away from where workshop participants are located (outside the Milwaukee area) in order to increase options.		
			Look into offering more resources that are free of cost	Specifically, participants emphasized that when searching for resources, we should proactively look for those which are free, as to proactively eliminate anticipated barriers in access.		
		<p>Proactively form alliances with groups/organizations</p>	--		Participants suggested we develop alliances (i.e., partnerships) with different organizations/entities (can establish partnerships at the beginning of a grant and allocate grant funds to pay for services and resources).	
			Alliances with student groups/trainees		Participants suggested the possibility of forming partnerships with student groups or students-in-training to help with short-term triage.	
			Alliances with community health workers		Participants discussed the value of strengthening alliances with community health workers who may be more equipped to help the community navigate systems and to provide additional guidance/support (with the recognition that community health workers may also be limited and at capacity)	
		<p>Strengthen information on how to navigate systems and take advantage of resources</p>	--		Participants emphasized the importance of expanding workshop content, and community events more broadly, to explicitly address the issues of navigating systems. While participants discussed extensively the importance of the research team's initiative, here they also mention the value of teaching group members how to take the initiative themselves to take advantage of resources.	
			--	--	The component was deemed highly satisfactory among participants.	
		<p>Connection to community resources is an acceptable component</p>	<p>Participants liked that resources are provided and revisited throughout the duration of the study</p>	--		Participants particularly appreciated how our team provides ongoing resources in an iterative manner throughout the course of the study.
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			Participants liked that we offer resources specifically for undocumented immigrants	--	Participants appreciated that we intentionally seek out and provide resources for undocumented immigrants, recognizing both the lack of and need for these specific services.
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Appendix I:
Pillar-Building Integration Model (Johnson et al., 2017)

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**Appendix J:
Pillar-Building Integration (Joint Display of QUANT and QUAL Data)**

Quantitative data	Quantitative categories	Pillar themes	Qualitative categories	Exemplary quotes
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Mindfulness Training Component				
<i>Mindfulness training is agreeable and appealing: M=4.27, SD= 1.024; m=5</i>	The component as a whole is acceptable in terms of its agreeableness and appeal.	High acceptability	Certain qualities of this component are favorable, including that it is actionable and easily accessible.	“This topic is much better than [psychoeducation] because mindfulness practice is something that they [intervention participants] can take action on.”
<p><i>Acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics: M=3.59, SD= 1.059; m=4</i></p> <p><i>Adequately addresses the topic of acculturative stress: M=3.88, SD=.944; m=4</i></p> <p><i>Holds the potential to have a positive health impact by reducing acculturative stress: M= 4.40, SD=.822; m=5</i></p>	Some dimensions of cultural appropriateness (i.e., that the component respects Latinx values and adequately addresses acculturative stress) were notably lower.	Views on religion and acculturative stress may modulate perceived appropriateness of mindfulness.	<p>There is a vast heterogeneity in religious preferences/affiliations. Three distinct clusters of perspectives emerged:</p> <ol style="list-style-type: none"> 1. The component is culturally appropriate if it incorporates religious elements. 2. The component is inherently not culturally appropriate because it is incompatible with religion (i.e., religious elements should replace component). 3. The component is culturally appropriate because it does not have a religious association (i.e., focus solely on the technique). <p>The connection between acculturative stress and mindfulness should be more explicitly addressed.</p>	<ol style="list-style-type: none"> 1. “Consider how spiritual and religious values and practices such as prayer can be incorporated.” 2. “Mindfulness from that deeply connected cultural perspective seems to me like a cartoon version of true spirituality” 3. “More than anything, it’s about

				<p>teaching the technique.”</p> <p>“[Incorporate the] mindful acceptance of the reality of acculturative stress.”</p>
Values Assessment Component				
<p><i>Values assessment is agreeable and appealing: M=4.45, SD=.827; n=5</i></p>	<p>The component as a whole is acceptable in terms of its agreeableness and appeal.</p>	<p>High acceptability</p>	<p>The component’s focus on goal setting (i.e., actionable, achievable targets) is particularly appealing.</p>	<p>“The goal setting following values [identification] is the most important part... [It] relates to clear habits and milestones and should be the highlight [of the component]. Without that, there is no clear action to take.”</p>

<p><i>Acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics: M=4.47, SD=.763; m=5</i></p> <p><i>Adequately addresses the topic of acculturative stress: M=4.21, SD=.890; m=4</i></p> <p><i>Holds the potential to have a positive health impact by reducing acculturative stress: M= 4.44, SD=.826; m=5</i></p>	<p>All appropriateness dimensions were rated highly, with “adequately addresses the topic of acculturative stress” observing a slightly lower rating compared to the other two dimensions.</p>	<p>Values assessment was perceived as both a culturally challenging and appropriate exercise.</p>	<p>Participants noted how maintaining values can be difficult amid uncontrollable acculturative stressors and due to a lack of attention to this topic historically. Yet, they still believed the topic is valuable to the community.</p>	<p>“This [component] is probably one of the most challenging components given the nuance in moving forward in alignment with your values even in the face of uncontrollable acculturative stressors - but I believe [it] can be immensely valuable.”</p> <p>“Have patience with the community with that word to assimilate [it]. Like ‘mental health’ it is not easy to digest for the community...historically it [mental health] has not been talked about much and [now] it has [been] assimilated with time.”</p>
Structured Problem-Solving Component				
<p><i>Structured problem-solving is agreeable and appealing: M=4.38, SD=.775; m=5</i></p>	<p>The component as a whole is acceptable in terms of its agreeableness and appeal.</p>	<p>High acceptability</p>	<p>Participants found the component to be agreeable due to its easy-to-follow, practical, and digestible nature.</p>	<p>“This [structured problem-solving] is stupendous to me. The matter is practical. There are people who think sequentially... [and people who] perceive everything at once...it’s very instructive for the person that cannot [think sequentially]. This gives them another perspective.”</p>

<p><i>Acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics: M=4.05, SD=.956; m=4</i></p> <p><i>Adequately addresses the topic of acculturative stress: M=4.19, SD=.855; m=4</i></p> <p><i>Holds the potential to have a positive health impact by reducing acculturative stress: M= 4.38, SD=.735; m=4</i></p>	<p>Participants generally agreed that the component fulfills each dimension of cultural appropriateness; notably, however, none of the dimensions received a median rating of 5.00 (strongly agree).</p>	<p>Enriching “form” may optimize appropriateness of structured problem-solving.</p>	<p>Participants recognized the process of solving problems as important; however, they suggested ways to incorporate more cultural elements into the practice to enhance application. Participants also pointed to a greater attention to the importance of creating space to acknowledge and explore structural inequities that may limit the cultural appropriateness and utility of the component.</p>	<p>“...Need to remember generational differences in our Latinos, with older Latinos being more 'intuitive' and wanting to contemplate a situation, maybe using 'dichos' and 'historias' to help define the problem or situation, before acting.”</p> <p>“The only hesitation here might be the complexity of problems that have both solvable and unsolvable components and helping participants to identify what they do have control over. Sometimes situations/problems can be partially solved or improved, but not completely, which makes the process a bit more nuanced.”</p>
Interpersonal Skills Training Component				
<p><i>Interpersonal skills training is agreeable and appealing: M=4.45, SD=.800; m=5</i></p>	<p>The component as a whole is acceptable in terms of its agreeableness and appeal.</p>	<p>High acceptability</p>	<p>Participants found several aspects of the component satisfactory; they appreciated how it aims to foster social connection and improve familial functioning.</p>	<p>“Really important focus on addressing family conflict and stressors.”</p> <p>“I love the idea of the social connectedness part.”</p>

<p><i>Acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics: M=4.32, SD=.885; m=5</i></p> <p><i>Adequately addresses the topic of acculturative stress: M=4.38, SD=.907; m=5</i></p> <p><i>Holds the potential to have a positive health impact by reducing acculturative stress: M= 4.45, SD=.862; m=5</i></p>	<p>Participants strongly agreed that the component satisfies each dimension of cultural appropriateness.</p>	<p>Familial negotiation and balance: key factors driving appropriateness of interpersonal skills training.</p>	<p>Participants described what they believe to be key principles of culturally grounded interpersonal skills training (i.e., negotiating values, biculturalism, and authority/permissibility).</p>	<p>“I have heard from community members that Latino parents commonly feel difficulties connecting with their teens, so...highlighting these parent-child gaps (for participants with children) [is] really important.”</p> <p>“One thing is authority, and another is authoritarianism.”</p>
<p>Psychoeducation Component</p>				
<p><i>Psychoeducation is agreeable and appealing: M=4.41, SD=.843; m=5</i></p>	<p>The component as a whole is acceptable in terms of its agreeableness and appeal.</p>	<p>High acceptability</p>	<p>Participants found the component to be appealing because it aims to increase knowledge acquisition, which can make a significant difference.</p>	<p>“It [psychoeducation] leans into the evidence that sometimes knowing alone can help people begin to feel less overwhelmed... they understand what they are going through.”</p>
<p><i>Acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics: M=4.30, SD=.840.; m=4</i></p> <p><i>Adequately addresses the topic of acculturative stress: M=4.18, SD=.881; m=4</i></p>	<p>Participants generally agreed that the component addresses all three dimensions of cultural appropriateness. However, no median ratings met the 5 (strongly agree) benchmark.</p>	<p>Extending psychoeducational content to dimensions of mental health may increase perceived appropriateness.</p>	<p>Participants identified several different dimensions of mental health they believe would be appropriate to cover within the scope of the prevention and promotion-based intervention. In this way, they appeared to believe it is not sufficient to address acculturative stress without also addressing co-occurring mental health issues and topics.</p>	<p>Include information about: “symptoms,” “how to seek help,” “de-stigmatizing mental health,” “mental health triggers before crisis,” “benefits of therapy vs. workshop.”</p> <p>“It may also be helpful to specifically discuss</p>

<p><i>Holds the potential to have a positive health impact by reducing acculturative stress:</i> <i>M=4.27, SD=.865.; m=4</i></p>				<p>ways in which communities are marginalized and intersectionality.”</p>
<p>Connection to Community Resources Component</p>				
<p><i>Connection to community resources is agreeable and appealing: M=4.28, SD=.958; m=4</i></p>	<p>While the component did not receive a median acceptability rating of 5 (strongly agree), participants nonetheless agreed it is acceptable in terms of agreeableness and appeal.</p>	<p>High acceptability</p>	<p>Participants appreciated how the component is revisited throughout the duration of the intervention and that resources are available to support the needs of undocumented immigrants.</p>	<p>“This is an excellent and important module. I am so excited to hear it...will be revisited throughout. I found myself worrying that there would not be enough to overcome the very real structural barriers that people may encounter, but seeing this video and the explanation makes me feel confident this will be a helpful and integral part of the intervention.”</p> <p>“I’m happy to hear the topic of access of undocumented individuals to resources, as most resources are not offered to these people.”</p>

<p><i>Acknowledges, respects, and incorporates cultural values, traditions, and beliefs of first- and second- generation Latinxs/Hispanics: M=4.26, SD=.986.; m=5</i></p> <p><i>Adequately addresses the topic of acculturative stress: M=4.39, SD=.919; m=5</i></p> <p><i>Holds the potential to have a positive health impact by reducing acculturative stress: M=4.51, SD=.798.; m=5</i></p>	<p>Participants strongly agreed that the component satisfies each dimension of cultural appropriateness.</p>	<p>Cultural appropriateness seems to be contingent upon, or driven by, how the connection is maintained with ongoing initiative and intentionality.</p>	<p>Participants highlighted that the component is culturally appropriate if the research team remains a committed, active agent in expanding the availability of resources, reducing barriers, disseminating tools/knowledge, and building partnerships.</p>	<p>"Increase the resources [and] decrease all the bureaucratic steps to truly achieve the goal of helping the community."</p> <p>"Regular informational talks can help people stay informed about the health resources that exist in the communities where they live."</p>
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