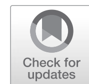

9 Behavioral Health Service Delivery with African Americans

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Introduction

Behavioral health is a broad term which generally describes the ways in which behavior, health, and the well-being of the body, mind, and spirit are connected. Behavioral health services often encompass treatment, intervention, and prevention of medical diagnoses and disorders such as substance abuse and other addiction, eating and drinking habits, and in recent years it includes all forms of mental health. Considering that 1 in 5 adults in the USA experiences mental illness in a given year (National Institute of Mental Health [NIMH], 2016), it is important for mental health specialists to think critically about the ways in which behavioral health services are delivered, particularly to underserved and consequentially at-risk populations. One such group is African Americans—who, despite recent attempts to advance mental health services for ethnic minority groups, continually receive inadequate and inferior mental health care.

Though African Americans do not experience greater prevalence of mental health conditions in comparison to the rest of the population (Primm, 2006), their mental health symptoms are often exacerbated by external factors such as discrimination, homelessness, abuse, trauma, and poverty. As such, African Americans disproportionately represent some of the most vulnerable populations, including poor, homeless, incarcerated, and foster care recipients at rates higher than Whites or any other ethnic minority group (U.S. Department of Health and Human Services [HHS], 2001). African Americans also live with experiences of everyday discrimination and racism which has negative effects on both their physical and mental health (HHS, 2001; Jackson et al., 1996; Kwate & Goodman, 2015). As a result, they are less likely to receive care and more likely to endure untreated symptoms and prolonged suffering.

The USA is now more culturally diverse than it has ever been and will only continue to become increasingly so. By 2060, the Black US population will increase from the current approximate 41.2 million to 61.8 million, increasing the total Black population by 1.6% (U.S. Census Bureau, 2016). These statistics point to the urgency of improving the delivery of behavioral health services to ethnic minorities in general, but for the purpose of this chapter, specifically to African Americans and people of African descent.

The term *African American* is most commonly used to describe people of African descent living in the USA; however, this group is comprised of different cultures and origins, and is becoming increasingly more diverse itself. Other diasporic groups tend to be more recently included among *Black Americans*, such as immigrants, refugees, descendants of the Caribbean, and African

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nations. So not all Black people are African American (ethnic group), but all African Americans are considered Black (racial group). Because of the pervasive negative stereotypes about African Americans and the awful cultural history of subjugation and enslavement, many Black immigrants are reluctant to identify with the African American label and feel very distinct culturally. Many Black immigrants generally have better mental health than African Americans, although the longer they live in the USA, the worse their mental health becomes (e.g., Soto, Dawson-Andoh, & BeLue, 2011; Williams et al., 2007). Given the diversity of Blacks in America and the historical and cultural factors that complicate their mental health and psychiatric experience, this chapter does not have the means to address the mental health issues of *all* Black Americans. We will be focusing on *African Americans,* in reference to people of African heritage who reside in the USA and are socialized into American culture. Correspondingly, non-Hispanic White people in the USA will be referred to here as *European Americans*.

This chapter will highlight the complex influence of cultural, historical, and experiential factors on mental disorders in African American communities. We will begin with a review of disparities in diagnosis and variation of symptomatology in several mental disorders among African Americans in comparison to European Americans. We will then discuss some of the barriers often present in the face of treatment, and consider key components for facilitating treatment with African Americans. Next, we will review practices for increasing clinician efficacy with African American clients. We will then conclude with recommended resources and future directions that will lead to the delivery of quality and accessible behavioral health services for African Americans.

Misdiagnosis and Symptom Differences

Past and current prevalence rates across various mental health disorders illustrate both the over and underdiagnosis of African Americans in comparison to European Americans (Atkins-Loria, Macdonald, & Mitterling, 2015). Although research has indicated few differences in prevalence rates, this is likely due to investigative protocols' emphasis on precise diagnostics, as clinical settings show a large gap in race-based diagnostic disparities. Further research is needed to determine the extent to which this discrepancy is due to misdiagnosis or actual variations in psychopathology between racial groups (Liang, Matheson, & Douglas, 2016); however, numerous social and cultural influences have been indicated as contributors, including differences in symptom expression (Chapman, DeLapp, and Williams, 2018). As proper diagnosis is imperative to accessing appropriate treatment, it is essential that health professionals accurately identify symptoms and understand social/cultural impacts on the assessment of disordered symptoms in African American clients. The following sections discuss diagnostic considerations for disorders in which African Americans are over or under represented.

Psychotic Disorders

Psychotic disorders are possibly one of the most studied mental health diagnosis disparities in African Americans. African Americans may be four to five times more likely than European Americans to receive the diagnosis of schizophrenia (DeCoux Hampton, 2007). When severe mental illness is present, African American youth in an inpatient setting are more frequently diagnosed with schizophrenia (Liang et al., 2016) and adults are more likely to have their previous diagnosis changed to schizophrenia, as well as to retain the diagnosis after completing care. Additionally, African Americans born in the USA are more likely than European Americans to be admitted to a psychiatric hospital (Snowden, Hastings, & Alvidrez, 2009), and rates of overdiagnosis can increase when African Americans are assessed by a clinician as opposed to self-report measures (DeCoux Hampton, 2007). A contribution to the difference in symptom ratings between clinicians and patients may be cultural mistrust or healthy cultural paranoia. African Americans'

knowledge of historical and current subjugation and maltreatment in medicine may cause severely mental ill patients to distrust European American providers and appear more paranoid to clinicians (Whaley, 2001; Whaley, 2004); however, it is important for providers to understand the real-world context in which cultural mistrust is rooted. Cases of providers using deception to harm African Americans are numerous, from kidnapping freed-slaves for experimental dissections to the continued involuntary sterilization of girls and women (Suite, La Bril, Primm, & Harrison-Ross, 2007). The most widely known abuse may be the U.S. Public Health Service Syphilis Study at Tuskegee (1932–1972) experiments, in which physicians mislead African American men with syphilis about their study participation with the intention to continually withhold curative treatment so their corpses could be examined (Centers for Disease Control and Prevention [CDC], 2017; Hunter & Schmidt, 2010). With collective narrative surrounding recent and long-standing provider dishonesty, there may be little surprise that African Americans with severe mental illness may prefer providers of the same race and have increased paranoid schizophrenia diagnoses, even when controlling for symptomology (Whaley, 2001). Further, experiences of racism may contribute to the development of psychotic disorders. A review article by Berger and Sarnyai (2015) integrated correlational and longitudinal data demonstrating that experiences of racism may increase psychotic symptoms in people of color. This further reflects the importance of cultural perspective in the diagnosis of psychotic disorders.

Major Depressive Disorder

Major depressive disorder (MDD) may be underdiagnosed in African Americans, and despite longer depressive episodes, African Americans receive less adequate treatment than European Americans (DeCoux Hampton, 2007; Walton & Payne, 2016; Williams et al., 2007). Misdiagnosis and underdiagnosis can be impacted by African Americans' underutilization of outpatient mental health care and increased symptom severity, including depressive psychosis, upon accessing inpatient care (DeCoux Hampton, 2007). Poor provider–client communication could also be to blame, as clinicians are more likely to downplay (Das, Olfson, Mccurtis, & Weissman, 2006) or misattribute African Americans' mood symptoms (i.e., psychomotor retardation mistaken for loafing; DeCoux Hampton, 2007). African Americans lowered likelihood of initiating conversations about depressed mood and differential mood symptom expression due to cultural values/norms may also contribute to diagnostic difficulty (Baker, 2001; Walton & Payne, 2016). Baker (2001) outlined three differential expressions of depression in African Americans: (1) "The John Henry doer," who may work excessively to the detriment of their health due to unrealistic standards for self and others, (2) "the stoic believer" characterized by the minimization of depressive symptoms due to religious devotion, and the (3) "angry 'evil' one" who exhibits increased agitation, curtness, and anger, which may increase clients' risk of dysregulated or self-destructive behavior. When assessing depressive mood symptoms in African Americans, differential cultural presentations and efforts to improve communication and validation of symptoms should be considered.

Although African Americans may minimize or express depressive mood symptoms differently, they are equally as likely to mention disordered symptoms within primary care settings as European Americans. These discussions of depressive symptoms often surround neurovegetative and somatic symptoms (Das et al., 2006; DeCoux Hampton, 2007), making it increasingly difficult and important for clinicians to correctly identify the physical symptoms of depression in African Americans. Such symptoms often reported in African Americans with depression are reduced appetite, insomnia, psychomotor impairment, pain, and poor overall health (Das et al., 2006; DeCoux Hampton, 2007). Payne (2014) conducted a study with 218 licensed masters-level therapists to understand how client

race may impact clinicians' diagnosis. The study showed clinicians one of four videos, two with an African American or European American male client displaying classic depressive symptoms, and the other two displaying some of the aforementioned culturally influenced symptoms of depression in African Americans. The symptoms expressed in all four videos were designed to meet criteria for MDD only; however, when clients expressed culturally influenced symptoms, regardless of client race, clinicians were much less likely to diagnose depression (68% vs 15%), and more likely to label symptoms as a behavior-related, bipolar, or mood disorder NOS (Payne, 2014). Clinician education in differential symptom expression is essential for accurate diagnosis and treatment for depression in African Americans.

Generalized Anxiety and Panic Disorder

Anxiety disorders, such as generalized anxiety disorder (GAD) and panic disorder (PD), are less frequently diagnosed in African Americans, although those with a diagnosis may have a longer duration of illness than European Americans. This underdiagnosis can be impacted by African American clients' discomfort with disclosing cognitive or emotional symptoms of anxiety due to cultural mistrust and stigma towards mental health (Hunter & Schmidt, 2010). However, much like MDD, African Americans are more likely to disclose physical symptoms of anxiety (Hunter & Schmidt, 2010), particularly since cardiovascular illness, which some anxiety symptoms may mirror (Sung et al., 2018), is a prevalent concern within this community. Misinterpretation of anxiety symptoms as cardiac illness prevents clients from receiving effective treatment, and African Americans' distress can worsen when experiencing physical anxiety symptoms, as they may feel more vulnerable to poor cardiac outcomes, leading to more anxiety about their health (Gordon & Teachman, 2008). Like many other disorders, GAD has been connected to experiences of racism in African Americans (Soto et al., 2011), as the unpredictable nature of discrimination may be particularly anxiety-inducing.

Obsessive-Compulsive Disorder

OCD is a quite heterogeneous disorder, and misdiagnosis is common among African Americans because patients who do not meet the most common OCD presentations (i.e., contamination fears and overt repetitive checking) may not be recognized quickly for intervention. Research has identified symptom dimensions that are similar to those found in previous studies of predominantly European and European Americans, including contamination/washing, symmetry/perfectionism, doubts about harm/checking, sexual obsessions/reassurance, and aggression/mental compulsions.

African Americans with OCD were more likely to endorse not being understood clearly as a primary concern when compared to European Americans (Williams, Elstein, Buckner, Abelson, & Himle, 2012). This finding, along with more commonly endorsed concerns related to contamination, potentially indicates that specific cultural experiences and values may influence the presentation of obsessive compulsive symptoms in African Americans. For example, experiences with disenfranchisement as a result of ethnic and racial discrimination may further perpetuate anxiety about not being heard or understood, while prejudiced assumptions about the cleanliness of African Americans may further perpetuate contamination concerns (Williams, Debreaux, & Jahn, 2016). Additionally, research has shown a connection between experiences of discrimination and severity of symptoms (Williams et al., 2017).

Post-traumatic Stress Disorder

Although African Americans may have a lower prevalence of anxiety disorders, the National Survey of American Life (NSAL) found that

African Americans have a higher prevalence rate for PTSD, at 9.1% versus 6.8% in non-Hispanic Whites (Himle et al., 2009). PTSD may be more disabling for African Americans who experience significantly more impairment at work and in carrying out everyday activities (Himle et al., 2009). African Americans have high rates of trauma exposure. Half have reported experiencing someone close to them die unexpectedly, almost half have been victims of assaultive violence, and nearly one in five has been in a life-threatening car accident. Males have frequently been exposed to war-related combat and over a third have been mugged. Among African American women, over one in six have been badly beaten by a spouse, over one in six have been raped, and one in five has experienced another kind of sexual assault (Ching, Williams, & Taylor, 2018).

Experiences with racial discrimination are another reason African Americans experience higher rates of PTSD, also termed *racial trauma* (Butts, 2002). Common examples include harassment by law enforcement and mistreatment in the workplace (Williams, Metzger, Leins, & DeLapp, 2018). Racial discrimination is a stressor that induces distress, frustration, and anxiety, adversely affects mental and physical health. It often leads to increases in dysfunctional coping strategies, such as substance use, isolation, and risky sexual activity.

Eating Disorders and Obesity

In examining eating disorders in African Americans, NSAL found that anorexia was a rare occurrence; in fact, not a single woman met criteria for anorexia in the previous 12 months, and there were no present or lifetime reports of anorexia in Caribbean adults in the study. These findings indicate that African Americans are at lower risk of anorexia than their European American counterparts, and Caribbean Americans are at an even lower risk. However, among those who did have a diagnosis, the age of onset for anorexia was lower for African American adults (14.9 years) in comparison to a similar national study with primarily European Americans, whose age of onset was during late adolescence (18.9 years). It appears that when African Americans do have anorexia, the age of onset is lower and the course of the disorder is longer (Franko, 2007).

These lower rates of anorexia are thought to be due to African American culture's reduced emphasis on thinness operating as a protective factor, as African American men may prefer women with curvier figures. Nonetheless, African American women can still feel social pressure to be thin. Lifetime prevalence rates found for bulimia in African Americans is 1.5% for adults, which is slightly higher than the national average of 1.0%. The average age of onset is 19 years, which is the same as the general population. Successful prevention efforts should not focus on body image or disordered eating directly, but rather address the thinness ideal indirectly, or focus on promoting healthy eating in lieu of eliminating unhealthy habits (Franko, 2007).

Binge eating was the most prevalent eating disorder among African Americans, with a lifetime prevalence of 1.7%, although 5.1% exhibited some problems with binge eating whether or not they met criteria for a disorder (Franko, 2007). Among all demographics, African American women have the highest obesity rates. African American women struggle more to lose weight after pregnancy. They also eat fewer fruits, vegetables, and whole grains, and consume more added sugars, sodium, and calories from fat when compared to women of other groups. Further, African American women engage in less leisure-time physical activity compared with African American men and people of other racial and ethnic groups. Hair care practices are a common barrier to physical activity among African American women, as getting hair wet through sweating or swimming may necessitate extra hours for grooming (Agyemang & Powell-Wiley, 2013).

Attention-Deficit Hyperactivity Disorder

African American children are also impacted by disparities in diagnosis. Attention-deficit hyperactivity disorder (ADHD) is less commonly diagnosed among African American children (Liang et al., 2016), with one study finding them to be 69% less likely than European American children to receive the diagnosis (Morgan, Staff, Hillemeier, Farkas, & Maczuga, 2013). African American children with an ADHD diagnosis or symptoms are also less likely to use medications to manage symptoms (Morgan et al., 2013), even when controlling for factors such as symptom severity, comorbid symptoms (i.e., conduct and oppositional defiant disorder), and household income (Coker et al., 2016). Being male and exhibiting problematic externalizing behaviors increase the odds that an African American child will receive an ADHD diagnosis (Morgan et al., 2013), meaning that girls with ADHD and those with primarily inattentiveness are at risk for a missed diagnosis.

Autism Spectrum Disorder

African American children with autism spectrum disorder (ASD) are more likely to have a delay in diagnosis than European American children, with an average delay of about 1.5 years. These children were misdiagnosed three-fold over European American children and were more likely to have an initial diagnosis of a conduct-related or adjustment disorder (Mandell, Ittenbach, Levy, & Pinto-Martin, 2007). This delay in identification can be devastating for long-term outcomes, as early intervention is critical for optimal language development and reduced symptom severity long term. African American parents of autistic children who worry about healthcare discrimination may encourage their children to become more independent, and thus appear higher functioning than they actually are (Burkett, Morris, Manning-Courtney, Anthony, & Shambley-Ebron, 2015). The misinterpretation of symptoms, such as externalized behavioral problems, on the part of parents and clinicians may also contribute to increased diagnosis delay (Burkett et al., 2015; Mandell et al., 2007). Unfortunately, clinicians' cultural biases may lend to the perception that African American children's externalizing behaviors are more important to address, leading to an increase in the misdiagnosis of ASD as conduct-related disorders (Liang et al., 2016). Research on autism in African Americans is sorely lacking.

Conduct Disorder

Conduct disorder (CD) is more often diagnosed in African American populations, particularly in low-income areas, adolescents, and city residents (Mizock & Harkins, 2011). Although this overdiagnosis is influenced by a number of factors, there has been insufficient research on the impact of historical inequity and biased sociocultural attitudes on overdiagnosis (Atkins-Loria et al., 2015). African Americans, particularly males are more likely to be inequitably punished by teachers and targeted by law enforcement, leading to higher rates of disciplinary actions, delinquency, and legal problems. Additionally, in impoverished neighborhoods, which are disproportionately African American, youth may join gangs for protection. These type of problems are all part of the diagnostic criteria for conduct disorder, leading to inflated prevalence rates among African American youth.

Across race, a diagnosis of CD can impact youths' legal and clinical outcomes, including more severe sentencing, moving youth cases to adult courts, and lower provider expectations for clinical improvement and law-abiding behavior, which may lead to lower quality treatment (Atkins-Loria et al., 2015; Rockett, Murrie, Boccaccini, & Deleon, 2007). Outcomes are particularly disturbing in regards to racial disparities in CD. Even when symptoms and crimes are comparable, African Americans are diagnosed with CD more often than European Americans, are incarcerated at higher rates, and are more

likely to have criminal activity accredited to personality as opposed to situational factors (Bridges & Steen, 1998; Mizock & Harkins, 2011). Clinicians may contribute to this disparity when utilizing risk assessments allowing for subjective bias, evaluating African American youth with less regard for environmental factors, using prevalence rates among African Americans to inform a CD diagnosis, and/or having reduced cultural competence (Mizock & Harkins, 2011). These disparities in incarceration and quality clinical care can prevent African Americans from experiencing equal juvenile justice outcomes, taking more years of freedom from African American youth with a CD diagnosis through increased prison time, due to lower quality assessments and legal bias.

Barriers to Treatment

Treatment Issues

Mental health disparities, or unfair differences in the quality of health care according to race and ethnicity, are common even when controlling factors related to accessibility, such as insurance status and income (Smedley, Stith, & Nelson, 2003). Studies show that African Americans often utilize general health services when seeking treatment for mental health concerns, resulting in inadequate depth and quality of treatment (Neighbors, Caldwell, & Williams, 2007; Primm, 2006). African Americans may consider a primary care provider (PCP) more ideal than a mental health specialist, since psychotherapy is often considered to be something "for White people." Seeking behavioral treatment of any kind is highly stigmatized, and Black culture is generally socialized against it.

African Americans who overcome stigma and are able to seek treatment are left to navigate an expensive and fragmented medical system with numerous administrative obstacles. Consequentially, many end up unable to access the mental health care they need. The insurance factor is a vital one as it has been shown to have significant implications on the quality of care patients receive; patients with public funded insurance receive a lesser quality of care than those with private insurance (Smedley et al., 2003). Coverage for substance use and mental health services, if included at all, is substantially lower than coverage for other medical illnesses and is significantly more expensive. Despite the passage of the Affordable Care Act in 2010, which greatly expanded insurance coverage, barriers remain in both access to and quality of care; this includes the availability of culturally informed services. There are not enough mental health clinicians of color to meet the needs of the whole African American community due to disparities in education and opportunities. African Americans only make up 2% of psychiatrists (Duffy et al., 2004), 6.5% of psychologists, but 23.5% of social workers (U.S. Bureau of Labor Statistics, 2018). Thus, culturally competent care is even more crucial to improving utilization of services and effectiveness of treatment for African American communities. Services lacking cultural sensitivity often perpetuate negative stereotypes which can further stigmatize the act of seeking treatment (Thompson, Bazile, & Akbar, 2004). This can make it difficult to connect with mental health providers and contribute to the notion that mental health care is not relevant to African Americans.

Cultural mistrust decreases help-seeking behaviors and lowers participation in treatment. Within the African American community, cultural mistrust stems from several sources and includes a widespread lack of cultural competency among clinicians and therapists (HHS, 2001; Griffith, Johnson, Zhang, Neighbors, & Jackson, 2011; Williams, Duque, Chapman, Wetterneck, & DeLapp, 2017). Other factors that have cultivated mistrust of mental health services among African Americans are historical and current medical and research abuses (Suite et al., 2007). Mistrust relates to not only events such as the Tuskegee Syphilis Study but even more recent publicized abuses such as the Johns Hopkins Lead Paint Study and Guatemala STD Trials

(Gamble, 1997; HHS, 2001; Spriggs, 2004), along with abuses against Black people that might periodically appear on the evening news. This cultural knowledge along with ongoing confirmation of provider biases in the form of less respect and microaggressions perpetuate the cultural mistrust and stigma associated with higher African Americans attrition rates.

Treatment Engagement

Treatment engagement has been noted as a problem in the delivery of mental health care for African Americans (Waldrop & de Arellano, 2004). There are several factors that contribute to low engagement, including perceptions of therapy as being irrelevant to real-life problems, stigma and shame, family stressors, and lack of awareness of available resources (Williams, Beckmann-Mendez, & Turkheimer, 2013; Williams, Domanico, Marques, Leblanc, & Turkheimer, 2012). Treatment adherence is one area in which culture, race, and ethnicity have been clearly demonstrated as relevant to treatment success (Waldrop & de Arellano, 2004). The apparent relevance of treatment approach to problems experienced (such as discrimination, limited access to resources, or the overlap of treatment content with the client's own experiences) will improve client engagement and adherence. Cultural relevance has been shown to make a difference with the retention of information and knowledge (Wilson & Cottone, 2013), so a culturally informed approach to treatment is essential not only for the sake of avoiding attrition but also for ensuring that the work done in therapy is retained by the client and put into practice.

Medication Issues

African Americans may avoid care due to negative or inaccurate health beliefs about psychiatric medications (Schnittker, 2003). Common fears about medication are that it will change one's personality, cause dependence, and/or lead to loss of control. These fears may be exacerbated by the connection to stigmatizing notions about drugs of abuse and stereotypes about Black people as addicts. Further, taking medication may feel at odds with African American cultural values surrounding persevering through difficulties, and thus be considered "taking the easy way out." There is an important role for the therapist in educating African Americans with accurate information about medication for mental health conditions. It can be helpful to conceptualize mental disorders as biological conditions, which can be helped with biological interventions, such as medication. Further, therapists can talk to clients candidly about the pros and cons of therapy with or without concomitant medication. It should also be emphasized that for most conditions, such as depression and anxiety, therapy is likely to be more effective.

Clinician biases are a major factor in medication mismanagement for African American patients. Prescribers tend to underestimate depression and anxiety in African Americans and fail to properly medicate for these conditions. Further, assessments of dangerousness and potential for violence are overestimated for African Americans, in accordance with violent and criminal stereotypes. Black patients are then given higher doses of antipsychotic medications when compared to White patients with the same severity of illness (Woods et al., 2003). As a result Africans are less likely to receive needed SSRIs and more likely to be prescribed too much or completely unnecessary antipsychotic medications.

This is compounded by the fact that African Americans, like many other ethnic minorities, metabolize antidepressants and antipsychotic medications more slowly than Whites and may be more sensitive to the medications. This higher sensitivity is manifested in a faster and higher rate of response and more severe side effects, including delirium when treated with doses commonly used for White patients (Muñoz & Hilgenberg, 2006). Thus, African Americans may exhibit poorer medication compliance, which then may be misinterpreted as resistance to treatment. This may make the whole process of help

seeking for mental health care aversive for patients who may be reluctant to return for needed assistance. If medications are in fact warranted, this is an important place for the therapist to intervene. This may include reaching out to the client's current prescriber to provide input on diagnoses or helping the client locate someone who is culturally competent in working with African Americans. In such cases, a personal connection to the prescriber may be important for success.

Facilitators to Treatment

Providers' active effort to incorporating facilitators in behavioral health treatment utilization and retention for African Americans can promote higher quality access and care. These efforts may be multifaceted and the opportunity to improve services can begin with clinicians' and clients' initial encounters. African Americans who report optimistic expectations for treatment are increasingly satisfied with later treatment outcomes. These positive expectations can be cultivated when clients know of a loved one who has benefited from treatment, if they themselves have had affirmative past therapeutic experiences, or if the clinician instills a sense of optimism (Thompson et al., 2013). When implemented into practice, the following treatment facilitators may not only benefit African American clients directly but may also have a ripple effect, promoting optimistic expectations in others who interact with your client.

Provider and Treatment Transparency

Unfortunately, not all clients who access behavioral health services will have positive expectations of treatment. African American clients, or caregivers of child clients, may hold negative or ambivalent beliefs about the efficacy of therapeutic interventions; however, clinicians can facilitate a sense of understanding and transparency by acknowledging early on that clients may not feel optimistic (Thompson et al., 2013). Collaborative therapeutic relationships that remain authentic and honest can convey to clients that their needs are being heard and are considered important (HHS, 2014). Engaging in open communication allows space for client's viewpoints and concerns to be acknowledged potentially increasing their likelihood of remaining in care (Carpenter-Song, 2010).

It is also vital that, in return, clinicians are open with African American clients when discussing treatment approach, timelines, and goals, as transparency surrounding intentions for treatment can reduce cultural mistrust and provide additional opportunities for clinician–client collaboration. Transparency concerning treatment goals and planning can encourage collaboration and shared ownership of the treatment direction, but it can also encourage treatment retention for African American clients by clarifying the practical benefits of treatment. African Americans may be more likely to end behavioral health interventions prematurely if there is no clear connection between treatment strategies and their impact on client's concerns (Carpenter-Song, 2010). Thus, communicating clear and definable mechanisms by which a given treatment can impact real-world change in client's symptoms and their personal circumstances can demonstrate to African American clients the efficacy and value of therapeutic intervention. The benefits of therapy should not only stress its personal value but also potential improvements in one's ability function in the role of parent, spouse, caregiver, employee, and friend. Leveraging the importance of one's mental health for the collective good can help defuse the notion that treatment is strictly a personal, individualistic, and potentially self-indulgent endeavor.

Emphasizing Biological Factors for Families

African American clients may benefit from a number of culturally tailored emphases in treatment. As with positive expectations potentially having a

feedback loop effect, unfortunately, this may be true for negative family interactions in African Americans with mental illness. African Americans with OCD report greater occurrences of negative family interactions, which may be a leading risk factor to the development and maintenance of OCD and/or OCD behaviors may contribute to poorer interactions, as family members may experience stress and perceive symptoms as unwarranted (Himle et al., 2017). As alluded to previously, increasing an emphasis on the biological factors which contribute to disorders through psychoeducation may help destigmatize and reduce tensions within families, by countering the dominant cultural belief that client self-discipline can eliminate symptomatology. The conviction that individual responsibility and self-control are vital in overcoming behavioral and mood concerns can undermine African Americans' reliance on behavioral health services. The biological basis of disorders can help counter to this cultural concern (Carpenter-Song, 2010), so it remains important to continue fostering a collaborative relationship and not force this paradigm shift; however, incorporating a biological emphasis may also provide the foundation for more understanding among family members and legitimize the utilization of therapeutic interventions. Incorporating psychoeducation on biological factors in psychopathology can also illustrate the link between mental and physical health, which may be particularly salient considering African Americans likelihood of experiencing somatic symptoms and worry pertaining to poor health outcomes (Gordon & Teachman, 2008).

Sociocultural Considerations

Knowledge and utilization of African Americans' shared cultural values and experiences can facilitate therapeutic growth and alliance when integrated into behavioral health service delivery. Economic hardship is particularly salient in African American communities, with average household incomes more than $20,000 dollars less than their European American counterparts (Kawaii-Bogue, Williams, & MacNear, 2017). Considering income limitations and the insurance barriers previously mentioned, providing quality care at an affordable price can increase African Americans access and retention in behavioral health services. Even among African Americans who can afford care, the perceptions that treatment might not be valuable may deter willingness to initiate or remain in therapy. Implementing low-cost contingency management practices for African Americans with higher levels of distress and symptom severity can increase treatment retention, without significantly impacting institutions or providers finances (Bride & Humble, 2008; Post, Cruz, & Harman, 2006).

Emphasizing resilience and positive changes can also facilitate treatment retention. Stigma surrounding mental health disorders can be increasingly salient for African American clients and can impact feelings of self-worth (Kawaii-Bogue et al., 2017). Reducing clinical jargon and terms that may amplify the focus on deficits by addressing disordered symptoms as "concerns" or "challenges" can help reduce this stigma (Carpenter-Song, 2010). Focusing on clients' strengths and ability to overcome can encourage an empowering narrative (HHS, 2014), providing African American clients a sense of resiliency that may be consistent with cultural narratives surrounding racial struggle and triumph. Group treatment for African Americans may be well positioned to amplify this effect, as community members can build on their sense of resiliency through a collective narrative of empowerment (e.g., Carlson, Endlsey, Motley, Shawahin, & Williams, 2018).

Treatment Environment

Individuals are part of a larger social context which contributes to perception of comfortability and familiarity—significant aspects of the treatment environment. There are many facets to creating a comfortable space, and these differ by culture. In terms of creating ambiance, like everyone else, African American clients want to be comfortable in the environment. Clinicians

should always consider the décor of the counseling facility. Color schemes, music, African American-based magazines, Afrocentric cultural office artwork can all be critically important in making clients feel comfortable and welcome (Williams et al., 2013). Also consider shifting context and setting as needed. Therapy can come in many forms besides conversation or sitting in an office. Therapists might consider relocating therapy to other settings that allow the client to access healing with familiar venues and enjoyable activities (Parham, 2002). Such locations include local churches, community or recreational centers, schools, or favored restaurants.

Considering the importance of the communal environment in many African American communities, a therapist providing treatment within those communities may result in greater treatment initiation and engagement. Through partnership and community engagement on the part of the therapist, local hubs for galvanization and solidarity can also be an avenue for connecting community members with more formalized medical treatment. Further, when providing therapy in a communal setting, therapists would likely build a favorable reputation both with the client and the community members which can provide the therapist with organic access to the content and functionality of said culture and community. Therapists should take time to visit African American communities, patronize local businesses, and build a positive presence in the community.

Increasing Clinician Efficacy

Before working with African Americans, clinicians must be willing to examine their own (mis) perceptions and correct any stereotypical beliefs. Pervasive negative stereotypes about African American people include notions such as lazy, poor, unintelligent, criminal, and sexually predatory/deviant. If therapists believe these stereotypes, even to a small extent, it will become evident in the course of conversations and therapeutic interventions. For example, if a student is struggling in school, the therapist may suggest a tutor (working based on assumptions of decreased aptitude) when in fact a quiet study area may actually be what is needed (perhaps the student lives with extended family and the home too noisy or distracting). In this case, the therapist would have been better off taking more time to understand the problem, rather than jumping to a solution informed by negative stereotypes. Thus, it is critical that therapists learn to actively challenge their biases in this regard.

Building Trust and Rapport

Authenticity is an important virtue in African American culture. Due to dealing with a lifetime of covert racism, African Americans are socially programmed to look for subtle signs that European Americans are trustworthy, and this may be particularly relevant in healthcare. Even other people of color who are part of the greater healthcare establishment may not be automatically trusted, as they may be viewed as a tool of the White establishment. The more genuine and authentic the therapist is, the better the therapeutic rapport. If a provider comes across as quiet and distant, African American clients may assume the therapist is hiding something important from them or treating them differently due to their race. Although many therapeutic approaches emphasize interpersonal distance, a style that includes openness, warmth, transparency, and mutual vulnerability will be more palatable for African American clients. Consider that therapists are asking clients who have a history of being oppressed and betrayed to share personal information with a complete stranger. Further, as many African Americans are coming to therapy often as a last resort to deal with mental health concerns, they are often looking for practical solutions to their problems and may feel like they are in crisis (whether or not they openly admit to being in such a state).

As a result, certain types of therapies may be better suited to African Americans than others. We strongly recommend behavioral therapy supplemented with functional analytic psychotherapy (FAP) for African American clients (e.g., Graham-LoPresti, Gautier, Sorenson, & Hayes-Skelton, 2017; Miller, Williams, Wetterneck, Kanter, & Tsai, 2015), as FAP focuses on cultivating

an authentic therapeutic connection. Cognitive therapy may also be helpful, but given the high potential of inappropriate cognitive restructuring by therapists unfamiliar with the lived experience of racism, cognitive therapy should only be attempted by those clinicians with a very deep understanding of how racism functions in American culture. Certainly, non-CBT modalities can be helpful, but the opaque nature of psychoanalysis may fuel greater suspicion in African American clients, and other non-directive approaches may seem pointless and frustrating to clients with emergent needs for help.

Cultural sensitivity can be enhanced by broaching differences early in treatment. Unlike African American therapists, European American therapists have more discomfort discussing race in cross-racial dyads (Knox, Burkard, Johnson, Suzuki, & Ponterotto, 2003). White therapists may have difficulty discussing race because it may not be something they talk about frequently, but sweeping it under the rug can invalidate clients' experiences as a person of color. Raising the issue of race early in the therapeutic relationship conveys cultural sensitivity and may address clients' concerns about a racially different counselor. For example, a White therapist could say, "Sometimes clients feel uncomfortable working with a counselor of a different race; how is this for you?"

In counseling situations the role of the clinician is guided by a theoretical orientation as well as the beliefs about how and why clients will experience some relief and resolution (e.g., psychoanalysis, interpersonal, CBT). As you enter the therapeutic relationship, therapists are advised to promote themselves as vehicle for change rather than the agent of change, to help clients maintain a sense of control. Further, African Americans prefer for you "tell it like it is." It is important that at the outset of therapy, you as a therapist explain what you are doing and how it will work. If the process is mysterious it may generate suspicion and mistrust. Therapists are expected to use an array of skills and techniques that are intended to bring about some desired therapeutic outcome. The traditional tools you have learned as a therapist will continue to be useful for African Americans. However, European American counselors and therapists working with African American clients need to bring a special sensitivity and competence to a therapeutic relationship. Work with African Americans should be culturally specific to facilitate the process; in other words it will be helpful to understand cultural values and the Black experience in America (Parham, 2002).

Therapists should be attentive to the behaviors they use to build the therapeutic alliance, especially if they have utilized one set of behaviors for a long time, these may not be as effective with African American clients, who may be approaching the situation with caution. The therapist should openly acknowledge and validate African American distrust if it is present. Avoid pushing too hard, seeming interrogative, or premature interpretations; building trust takes time.

When greeting African Americans, the following guidelines can be helpful (Lee & Roberts, 2008). Shaking hands is common practice for both men and women. Be formal at the beginning and do not call an African American by their first name unless the person invites you to do so, as this could be insulting, particularly for older clients. Using formal titles, such as "Ms." or "Doctor" is a form of respect, and respect is a critical component of the African American value system. You can show also respect by saying something like, "It's really nice to meet you." In terms of personal space, African Americans are comfortable with closer and less formal distances, and may only be 1–2 feet away, but you must establish trust before assuming familiarity or closeness. Eye contact can be very direct, especially when speaking but may be indirect when listening. When building rapport, you can start with anything you would normally talk about with other long-established American cultural groups, such as the weather, entertainment, sports, or local news. Men may not always be comfortable talking about themselves right away, so therapists should not be put off if they seem guarded initially. Although African Americans

tend to prefer very direct verbal communication, non-verbal communication is very important and can convey more meaning than in almost any other culture, as gestures can be more enthusiastic than most non-African Americans are accustomed to. Finally, the African American culture has a long history of storytelling, so feel free tell stories to engage clients.

Afrocentric Values

Afrocentric values can help facilitate the treatment process. Afrocentric values should not be confused with the African American images seen in the media and commercial music, which emphasize materialism, commercialized hip-hop, drug culture, stereotypes, and urban clothing. It is easy to confuse cultural values and stereotypes. Remember, pathological stereotypes are overgeneralized or false ideas about a group that is advanced to justify or explain inequities. Cultural values, on the other hand, are actual differences in the beliefs, attitudes, and practices of a particular group. These represent average differences, and so obviously, not everyone in a given cultural group identifies with all of their group's cultural values. Even so, most people in that cultural group will understand and appreciate the differences, even if they do not adhere to them.

Afrocentrism is rooted in idealized African values and can be an excellent vehicle for promoting healing in African American clients. In an Afrocentric worldview, spirituality is a means of self-definition and a primary coping resource. Understanding the importance of spirituality within the African American community is crucial, as the church is a resource for religious, personal, family, and political support. Therapists will be viewed as more credible in this community if they are competent in religious and spiritual issues. Although not all clinicians are religious, the goal is to accurately understand individuals within their cultural context in order to best deliver culturally informed interventions.

The Afrocentric worldview has been highlighted by Parham (2002) as rooted in the following understanding:

- Self: In contrast to Eurocentric psychological models of the self that are fragmented (e.g., id, ego, superego; actions, behaviors, and cognitions), the Afrocentric self is viewed as a unitary, holistic entity, which is a reflection of one's inner spirit (i.e., spiritness made evident).
- Feelings: In contrast the notion that maturity and professionalism require silencing one's emotions, an Afrocentric approach values emotion. Emotions are legitimate, should be expressed, reflect one's vitality, and communicate aliveness. However, many African Americans have learned to stifle their emotions as a survival mechanism (i.e., "John Henryism," and the "cool pose").
- Survival: In contrast to competitive notions such as "survival of the fittest," the Afrocentric worldview values the collective. This is embodied in the African saying, "'I am because we are, and because we are, I am."
- Language: In contrast to written history, oral traditions pass down community history, allowing the living to feel connected to elders of past. Also, responses are valued after a statement is made as a recognition of understanding (i.e., call-response).
- Time: In contrast to the Eurocentric emphasis on precision, time is not measured through standard units, but by major life events and thus can be cyclical across the lifespan as events are re-experienced (i.e., births, marriages). Time is not treated as currency but an opportunity for shared experiences.
- Universe: In contrast to the notion that our surroundings are to be controlled, the universe is viewed as harmonious. Even within the hierarchy, from God to plants, all beings are connected.
- Death: Death is not seen as an end, but phase of life. Elders are among the most respected members and ascend the hierarchy as "living dead," gaining immortality through oral history.
- Worth: A person's value is not how much wealth they amassed during their lives, but rather value is measured by the contributions they have made to the community.

African American values include optimism, humor, creativity, resilience, perseverance, uniqueness, self-expression, healthy skepticism, being genuine, assertive, and honest. Additional strengths include the ability to adapt to changing societal and economic contexts, a strong work orientation, and drive to “make ends meet.” Appreciating and incorporating these values into therapeutic work can be a powerful means of progress and healing.

Respect Religious and Traditional Healing Practices

Many types of specialists may be involved in some facet of a client’s mental health care. These may include family doctors, psychiatrists, social workers, clergy, and other traditional healers. Therapists need to be aware of all the resources clients access for support to ensure harmonious and effective treatment while respecting the client’s values and culture.

In the face of what may appear to be worries of a spiritual nature (which may be present within anxiety, depression, OCD, and psychosis), a religious healer may seem like the most appropriate person to provide help. Churches built on African and African American heritage have historically served as a source for support and social services, such as alcohol and drug abuse recovery, health screenings, counseling, education, and other treatment-oriented programming (Blank, Mahmood, Fox, & Guterbock, 2002). As such, African Americans with mental health concerns may enlist pastors, elders, priests, prophets, and other religious healers for prayer, advice, and even “casting out of demons.” However, sometimes therapists are not in agreement that these type of healers are actually helpful, and there may even be a concern that religious approaches are making symptoms worse. Given a conflict between a therapist and clergy, the client will usually side with clergy and abandon the therapist. Thus, it is better to collaborate with the religious healer rather than force the client to make a choice. With the permission of the client, the therapist can reach out to the religious healer to describe the client’s problem and their own model for the therapeutic treatment approach. If the religious healer is supportive, then that will go a long way toward helping the client feel motivated to fully participate in therapy. It can also be helpful for the religious healer to know what practices, if any, are counterproductive for the client’s progress (Williams, Duque, et al., 2017).

Other than mainstream religions, there are many traditional practices used as ways to connect spiritually, medicinally, and even psychically. Many immigrants have introduced their approaches to health and well-being into Western culture, and so clients may be adherents of alternative traditional medicine. Such practices may include herbal medicine, Voodoo, Santeria, and New Age therapies. Therapists should be prepared to discuss the role of the traditional healer with their clients. Even if the therapist feels completely certain the traditional approach is not helpful, it is important to show respect for these systems. Indigenous, cultural, and traditional healing practices are time-honored methods that many have historically been used to alleviate both physical and psychological problems – sometimes for thousands of years. Although examples of traditional treatment that have caused harm are frequently cited, many find these approaches central to their well-being (Pouchly, 2012).

It is also important to understand that religion does not cause mental disorders. Even if the client’s disorder has religious themes therapists should be careful not to blame a client’s religion for symptoms. If the therapist mistakenly thinks that religion is causing the problem, this may result in efforts control or suppress the client’s beliefs to facilitate treatment. This is sure to undermine trust and empathy, leading to conflict and drop out. Therefore, the best approach is to work respectfully within the confines of the client’s religious beliefs and traditions to ultimately facilitate treatment engagement. In fact, it is much more effective to recruit the client’s religious values in service of treatment than to try to

suppress them. In most cases, the mental health problem has gotten in the way of carrying out proper religious duties (i.e., prayer, attendance at services, fellowship, important ceremonies) rather than improving religious life. The therapist can underscore that successful treatment will facilitate fuller participation in religious priorities and improve the client's connection with their spirituality (Williams, 2017).

Check-ins and Review of Progress

It is important to periodically share information with clients about how well they are progressing toward their goals. Periodic check-ins further promote change through review and renewal of commitment to the process. Clinicians may know what a client is experiencing in the moment, but more importantly, therapists need to know what a client has found facilitative or not helpful about particular aspects of therapy. Clients should be reminded throughout the treatment process that successful interventions rarely occur as a single moment in time but rather in a series of successive steps, each of which brings a client closer to their goals. Clients should be taught to anticipate setbacks, as work will include positive and negative outcomes. This may help in dealing with frustration in unplanned outcomes. One good gauge of progress is to examine whether the individual has been able to achieve a sense of balance and harmony in life. Finally, clients should be reminded that although they are in the moment, they are always in a state of becoming more self-actualized. (Parham, 2002). In other words, although there may be clear goals for therapy, growth is a journey not a destination.

Conclusions

The lack of mental health care for African Americans continues to be a major public health concern. The reduction of race-based mental health disparities in the delivery of behavioral health services includes many complexities, and as such, there is no single solution. However, many interventions have been presented which can work together to change the experience of mental health treatment for not just African Americans, but people of all ethnic groups. Although the behavioral healthcare system is fragmented, there are still new treatment approaches being developed, tested, and implemented on a regular basis. So long as these treatments and services aim to accommodate and include the needs and cultural sensitivities of African Americans and other groups, there is great promise for those in need of behavioral health interventions.

Resources

There are a number of resources that can help inform work with African Americans. Therapists can make use these and other resources as a means to reduce mental health disparities and help facilitate the critical development of holistic and culturally sensitive behavioral health services for African Americans, and other vulnerable populations.

- Black Psychiatrists of America (www.bpaincpsych.org).
- The National Association of Black Social Workers (www.nabsw.org).
- The Association of Black Psychologists (http://www.abpsi.org/).
- The Black Mental Health Alliance (www.blackmentalhealth.com).
- The Community Healing Network (https://www.communityhealingnet.org/).
- The HHS Office of Minority Health (https://www.minorityhealth.hhs.gov/).

References

Agyemang, P., & Powell-Wiley, T. M. (2013). Obesity and Black women: Special considerations related to genesis and therapeutic approaches. *Current Cardiovascular Risk Reports, 7*(5), 378–386. https://doi.org/10.1007/s12170-013-0328-7

Atkins-Loria, S., Macdonald, H., & Mitterling, C. (2015). Young African American men and the diagnosis of conduct disorder: The neo-colonization of suffering. *Clinical Social Work Journal, 43*(4), 431–441. https://doi.org/10.1007/s10615-015-0531-8

Baker, F. M. (2001). Diagnosing depression in African Americans. *Community Mental Health Journal, 37*(1), 31–38. https://doi.org/10.1023/A:1026540321366

Berger, M., & Sarnyai, Z. (2015). 'More than skin deep': Stress neurobiology and mental health consequences of racial discrimination. *Stress: The International Journal on the Biology of Stress, 18*(1), 1–10. https://doi.org/10.3109/10253890.2014.989204

Blank, M. B., Mahmood, M., Fox, J. C., & Guterbock, T. (2002). Alternative mental health services: The role of the Black church in the South. *American Journal of Public Health, 92*(10), 1668–1672.

Bride, B. E., & Humble, M. N. (2008). Increasing retention of African-American women on welfare in outpatient substance user treatment using low-magnitude incentives. *Substance Use & Misuse, 43*(8–9), 1016–1026. https://doi.org/10.1080/10826080801914154

Bridges, G. S., & Steen, S. (1998). Racial disparities in official assessments of juvenile offenders: Attributional stereotypes as mediating mechanisms. *American Sociological Review, 63*(4), 554–570. https://doi.org/10.2307/2657267

Burkett, K., Morris, E., Manning-Courtney, P., Anthony, J., & Shambley-Ebron, D. (2015). African American families on autism diagnosis and treatment: The influence of culture. *Journal of Autism and Developmental Disorders, 45*(10), 3244–3254. https://doi.org/10.1007/s10803-015-2482-x

Butts, H. F. (2002). The black mask of humanity: Racial/ethnic discrimination and post-traumatic stress disorder. *Journal of the American Academy of Psychiatry and the Law, 30*(3), 336–339.

Carlson, M., Endlsey, M., Motley, D., Shawahin, L. N., & Williams, M. T. (2018). Addressing the impact of racism on veterans of color: A race-based stress and trauma intervention. *Psychology of Violence, 8*, 748.

Carpenter-Song, E. (2010). Familial responses to ADHD and bipolar spectrum disorders: Perspectives from a diverse group of families in the United States. *Directions in Psychiatry, 30*(1), 53–62.

Center for Substance Abuse and Treatment (CSAT), Substance Abuse and Mental Health Services Administration. (2014). *Treatment Improvement Protocol (TIP) 59: Improving cultural competence* (Report No. SMH14-4849). Retrieved from: https://www.ncbi.nlm.nih.gov/books/NBK248418/

Centers for Disease Control and Prevention. (2017). *U.S. Public Health Service Syphilis Study at Tuskegee*. Retrieved from https://www.cdc.gov/tuskegee/timeline.htm

Chapman, L. K., DeLapp, R., & Williams, M. T. (2018). Impact of race, ethnicity, and culture on the expression and assessment of psychopathology. In D. C. Beidel, B. C. Frueh, & M. Hersen (Eds.), *Adult psychopathology and diagnosis* (8th ed.). Hoboken, NJ: Wiley. ISBN:978-1-119-38360-4.

Ching, T. H. W., Williams, M. T., & Taylor, R. J. (2018, November). *Gender differences in lifetime trauma exposure among African Americans and Black Caribbeans*. Poster session at the 52nd Annual Convention of the Association of Behavioral and Cognitive Therapies, Washington, DC.

Coker, T. R., Elliott, M. N., Toomey, S. L., Schwebel, D. C., Cuccaro, P., Emery, S. T., … Schuster, M. A. (2016). Racial and ethnic disparities in ADHD diagnosis and treatment. *Pediatrics, 138*(3), e20160407. https://doi.org/10.1542/peds.2016-0407

Das, A., Olfson, M., Mccurtis, H., & Weissman, M. (2006). Depression in African Americans: Breaking barriers to detection and treatment. *The Journal of Family Practice, 55*(1), 30–39.

DeCoux Hampton, M. (2007). The role of treatment setting and high acuity in the overdiagnosis of schizophrenia in African Americans. *Archives of Psychiatric Nursing, 21*(6), 327–335. https://doi.org/10.1016/j.apnu.2007.04.006

Duffy, F. F., Wilk, J. W., West, J. C., Narrow, W. E., Rae, D. S., Hall, R., … Manderscheid, R. W. (2004). Mental health practitioners and trainees. In R. W. Manderscheid & J. T. Berry (Eds.), *Mental health, United States*. Rockville, MD: Center for Mental Health Services. Retrieved from https://store.samhsa.gov/shin/content/SMA06-4195/SMA06-4195.pdf

Franko, D. L. (2007). Race, ethnicity, and eating disorders: Considerations for DSM-V. *International Journal of Eating Disorders, 40*(53), S31–S34. https://doi.org/10.1002/eat.20455

Gamble, V. N. (1997). Under the shadow of Tuskegee: African Americans and health care. *American Journal of Public Health, 87*(11), 1773–1778.

Gordon, T. L., & Teachman, B. A. (2008). Ethnic group differences in affective, behavioral, and cognitive markers of anxiety. *Journal of Cross-Cultural Psychology, 39*(4), 424–446. https://doi.org/10.1177/0022022108318224

Graham-LoPresti, J. R., Gautier, S. W., Sorenson, S., & Hayes-Skelton, S. A. (2017). Culturally sensitive adaptations to evidence-based cognitive behavioral treatment for social anxiety disorder: A case paper. *Cognitive and Behavioral Practice, 24*(4), 459–471. https://doi.org/10.1016/j.cbpra.2016.12.003

Griffith, D. M., Johnson, J., Zhang, R., Neighbors, H. W., & Jackson, J. S. (2011). Ethnicity, nativity and the health of American Blacks. *Journal of Healthcare for the Poor and Underserved, 22*(1), 142–156. https://doi.org/10.1353/hpu.2011.0011

Himle, J. A., Baser, R. E., Taylor, R. J., Campbell, R. D., & Jackson, J. S. (2009). Anxiety disorders among African Americans, blacks of Caribbean descent, and non-Hispanic whites in the United States. *Journal of Anxiety Disorders, 23*, 578–590.

Himle, J. A., Taylor, R. J., Nguyen, A. W., Williams, M. T., Lincoln, K. D., Taylor, H. O., & Chatters, L. M.

(2017). Family and friendship networks and obsessive-compulsive disorder among African Americans and Black caribbeans. *The Behavior Therapist, 40*(3), 99–105.

Hunter, L. R., & Schmidt, N. B. (2010). Anxiety psychopathology in African American adults: Literature review and development of an empirically informed sociocultural model. *Psychological Bulletin, 136*(2), 211–235. https://doi.org/10.1037/a0018133

Jackson, J. S., Brown, T. N., Williams, D. R., Torres, M., Sellers, S. L., & Brown, K. (1996). Racism and the physical and mental health status of African Americans: A thirteen year national panel study. *Ethnicity and Disease, 6*(1–2), 132–147.

Kawaii-Bogue, B., Williams, N. J., & MacNear, K. (2017). Mental health care access and treatment utilization in African American communities: An integrative care framework. *Best Practices In Mental Health: An International Journal, 13*(2), 11–29.

Knox, S., Burkard, A. W., Johnson, A. J., Suzuki, L. A., & Ponterotto, J. A. (2003). African American and European American therapists' experiences of addressing race in cross-racial dyads. *Applied Psychology, 50*(4), 466–481. https://doi.org/10.1037/0022-0167.50.4.466

Kwate, N. O. A., & Goodman, M. S. (2015). Cross-sectional and longitudinal effects of racism on mental health among residents of Black neighborhoods in New York City. *American Journal of Public Health, 105*(4), 711–718. https://doi.org/10.2105/AJPH.2014.302243

Lee, M. S., & Roberts, R. R. (2008). *How to do business in the African American community. Cross-cultural selling for dummies*. Wiley. Retrieved from https://www.dummies.com/careers/business-skills/how-to-do-business-in-the-african-american-community/

Liang, J., Matheson, B. E., & Douglas, J. M. (2016). Mental health diagnostic considerations in racial/ethnic minority youth. *Journal of Child and Family Studies, 25*(6), 1926–1940. https://doi.org/10.1007/s10826-015-0351-z

Mandell, D. S., Ittenbach, R. F., Levy, S. E., & Pinto-Martin, J. A. (2007). Disparities in diagnoses received prior to a diagnosis of autism spectrum disorder. *Journal of Autism and Developmental Disorders, 37*(9), 1795–1802. https://doi.org/10.1007/s10803-006-0314-8

Miller, A., Williams, M. T., Wetterneck, C. T., Kanter, J., & Tsai, M. (2015). Using functional analytic psychotherapy to improve awareness and connection in racially diverse client-therapist dyads. *The Behavior Therapist, 38*(6), 150–156.

Mizock, L., & Harkins, D. (2011). Diagnostic bias and conduct disorder: Improving culturally sensitive diagnosis. *Child & Youth Services, 32*(3), 243–253. https://doi.org/10.1080/0145935X.2011.605315

Morgan, P. L., Staff, J., Hillemeier, M. M., Farkas, G., & Maczuga, S. (2013). Racial and ethnic disparities in ADHD diagnosis from kindergarten to eighth grade. *Pediatrics, 132*(1), 85–93. https://doi.org/10.1542/peds.2012-2390

Muñoz, C., & Hilgenberg, C. (2006). Ethnopharmacology: understanding how ethnicity can affect drug response is essential to providing culturally competent care. *Holistic Nursing Practice, 20*, 227–234

National Institute of Mental Health. (2016). *Mental illness: Prevalence of any mental illness*. Retrieved from https://www.nimh.nih.gov/health/statistics/mental-illness.shtml

Neighbors, H. W., Caldwell, C., & Williams, D. R. (2007). Race, ethnicity, and the use of services for mental disorders: Results from the national survey on American life. *Archives of General Psychiatry, 64*(4), 485–494. https://doi.org/10.1001/archpsyc.64.4.485

Parham, T. A. (2002). *Counseling persons of African descent: Raising the bar of practitioner competence*. Thousand Oaks, CA: Sage. https://doi.org/10.4135/9781452229119

Payne, M. (2014). *Modern social work theory*. Oxford University Press

Post, E. P., Cruz, M., & Harman, J. (2006). Incentive payments for attendance at appointments for depression among low-income African Americans. *Psychiatric Services, 57*(3), 414–416. https://doi.org/10.1176/appi.ps.57.3.414

Pouchly, C. (2012). A narrative review: Arguments for a collaborative approach in mental health between traditional healers and clinicians regarding spiritual beliefs. *Mental Health, Religion & Culture, 15*(1), 65–85.

Primm, A. (2006). Cultural issues in assessment and treatment: African American patients. In R. F. Lim (Ed.), *Clinical manual of cultural psychiatry* (pp. 35–68). Washington DC: American Psychiatric Publishing.

Rockett, J., Murrie, D., Boccaccini, M., & Deleon, P. H. (2007). Diagnostic labeling in juvenile justice settings: Do psychopathy and conduct disorder findings influence clinicians? *Psychological Services, 4*(2), 107–122.

Schnittker, J. (2003). Misgivings or medicine?: African Americans' skepticism of psychiatric medicine. *Journal of Health and Social Behavior, 44*(4), 506–524. https://doi.org/10.2307/1519796

Smedley, B., Stith, A. Y., & Nelson, A. R. (2003). *Unequal treatment: Confronting racial and ethnic disparities in health care*. Washington DC: National Academies Press (US). Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK220358/

Snowden, L., Hastings, J., & Alvidrez, J. (2009). Overrepresentation of black Americans in psychiatric inpatient care. *Psychiatric Services, 60*(6), 779–785. https://doi.org/10.1176/ps.2009.60.6.779

Soto, J. A., Dawson-Andoh, N. A., & BeLue, R. (2011). The relationship between perceived discrimination and Generalized Anxiety Disorder among African Americans, Caribbeans, and non-Hispanic Whites. *Journal of Anxiety Disorders, 25*(2), 258–265. https://doi.org/10.1016/j.janxdis.2010.09.011

Spriggs, M. (2004). Canaries in the mines: Children, risk, non-therapeutic research and justice. *Journal of Medical Ethics, 30*, 176–181.

Suite, D., La Bril, R., Primm, A., & Harrison-Ross, P. (2007). Beyond misdiagnosis, misunderstanding and mistrust: Relevance of the historical perspective in the medical and mental health treatment of people of color. *Journal of the National Medical Association, 99*(8), 879–885.

Sung, S. C., Rush, A. J., Earnest, A., Lim, L. C., Pek, M. P., Choi, J. F., … Ong, M. H. (2018). A brief interview to detect panic attacks and panic disorder in emergency department patients with cardiopulmonary complaints. *Journal of Psychiatric Practice, 24*(1), 32–44.

Thompson, R., Dancy, B. L., Wiley, T. A., Najdowski, C. J., Perry, S. P., Wallis, J., … Knafl, K. A. (2013). African American families' expectations and intentions for mental health services. *Administration and Policy in Mental Health and Mental Health Services Research, 40*(5), 371–383. https://doi.org/10.1007/s10488-012-0429-5

Thompson, V. L. S., Bazile, A., & Akbar, M. (2004). African Americans' perceptions of psychotherapy and psychotherapists. *Professional Psychology: Research and Practice, 35*(1), 19–26. https://doi.org/10.1037/0735-7028.35.1.19

U.S. Bureau of Labor Statistics, Division of Labor Force Statistics. (2018, January 19). *Employed persons by detailed occupation, sex, race, and Hispanic or Latino ethnicity*. Retrieved September 9, 2018, from https://www.bls.gov/cps/cpsaat11.htm

U.S. Census Bureau. (2016). *U.S. census bureau projections show a slower growing, older, more diverse nation a half century from now (Newsroom Archive - U.S. Census Bureau)*. Retrieved from https://www.census.gov/newsroom/releases/archives/population/cb12-243.html

U.S. Department of Health and Human Services (HHS), Center for Substance Abuse Treatment. (2014). *Improving cultural competence. Treatment Improvement Protocol (TIP) Series, No. 59*. Rockville, MD: U.S. HHS, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK248418/

U.S. Department of Health and Human Services (HHS), National Institute of Mental Health. (2001). *Mental health: Culture, race, and ethnicity – A supplement to mental health: A report of the surgeon general*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK44251/

Waldrop, A. E., & de Arellano, M. A. (2004). Manualized cognitive-behavioral treatment for physical abuse-related PTSD in an African American child: A case example. *Cognitive and Behavioral Practice, 11*, 343–352. https://doi.org/10.1016/S1077-7229(04)80051-8

Walton, Q. L., & Payne, J. S. (2016). Missing the mark: Cultural expressions of depressive symptoms among African-American women and men. *Social Work in Mental Health, 14*(6), 637–657. https://doi.org/10.1080/15332985.2015.1133470

Whaley, A. L. (2001). Cultural mistrust of white mental health clinicians among African Americans with severe mental illness. *American Journal of Orthopsychiatry, 71*(2), 252–256. https://doi.org/10.1037/0002-9432.71.2.252

Whaley, A. L. (2004). Paranoia in African-American men receiving inpatient psychiatric treatment. *Journal of the American Academy of Psychiatry and the Law, 32*(3), 282–290.

Williams, D. R., González, H., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean Blacks, and Non-Hispanic Whites: Results from the National Survey of American Life. *Archives of General Psychiatry, 64*(3), 305–315. https://doi.org/10.1001/archpsyc.64.3.305

Williams, D. R., Haile, R., González, H. M., Neighbors, H., Baser, R., & Jackson, J. S. (2007). The mental health of Black Caribbean immigrants: Results from the National Survey of American Life. *American Journal of Public Health, 97*(1), 52–59.

Williams, M., Debreaux, M., & Jahn, M. (2016). African Americans with obsessive-compulsive disorder: An update. *Current Psychiatry Reviews, 12*(2), 109–114. https://doi.org/10.2174/157340051266616060212414 6

Williams, M. T. (2017, January 29). Religious and traditional healers for OCD: Helpful or hurtful? Culturally Speaking [blog]. *Psychology Today*. Retrieved from https://www.psychologytoday.com/us/blog/culturally-speaking/201701/religious-traditional-healers-ocd-helpful-or-hurtful

Williams, M. T., Beckmann-Mendez, D., & Turkheimer, E. (2013). Cultural barriers to African American participation in anxiety disorders research. *Journal of the National Medical Association, 105*(1), 33–41.

Williams, M. T., Domanico, J., Marques, L., Leblanc, N., & Turkheimer, E. (2012). Barriers to treatment among African Americans with obsessive-compulsive disorder. *Journal of Anxiety Disorders, 26*(1), 555–563. https://doi.org/10.1016/j.janxdis.2012.02.009

Williams, M. T., Duque, G., Chapman, L. K., Wetterneck, C. T., & DeLapp, R. C. T. (2017). Ethnic identity and regional differences in mental health in a national sample of African American young adults. *Journal of Racial and Ethnic Health Disparities, 5*(2), 312–321. https://doi.org/10.1007/s40615-017-0372-y

Williams, M. T., Elstein, J., Buckner, E., Abelson, J., & Himle, J. (2012). Symptom dimensions in two samples of African Americans with obsessive-compulsive disorder. *Journal of Obsessive-Compulsive and Related Disorders, 1*(3), 145–152. https://doi.org/10.1016/j.jocrd.2012.03.004

Williams, M. T., Metzger, I., Leins, C., & DeLapp, C. (2018). Assessing racial trauma within a DSM-5 framework: The UConn racial/ethnic stress & trauma

survey. *Practice Innovations, 3*, 242–260. https://doi.org/10.1037/pri0000076

Williams, M. T., Taylor, R. J., Mouzon, D. M., Oshin, L. A., Himle, J. A., & Chatters, L. M. (2017). Discrimination and symptoms of obsessive–compulsive disorder among African Americans. *American Journal of Orthopsychiatry, 87*(6), 636–645. https://doi.org/10.1037/ort0000285

Wilson, C. J., & Cottone, R. R. (2013). Using cognitive behavior therapy in clinical work with African American children and adolescents: A review of the literature. *Multicultural Counseling and Development, 41*, 130–143. https://doi.org/10.1002/j.2161-1912.2013.00032.x

Woods, S. W., Sullivan, M. C., Neuse, E. C., Diaz, E., Baker, C. B., Madonick, S. H., … Steiner, J. L. (2003). Best practices: Real and ethnic effects on antipsychotic prescribing practices in a community mental health center. *Psychiatric Services, 54*(2), 177–179. https://doi.org/10.1176/appi.ps.54.2.177