Cognitive Behavioral Therapies

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Introduction

The emergence of cognitive behavioral therapies (CBT) since the early 1960s sparked a period, termed the "cognitive revolution" (Dobson & Dozois, 2010), a shift in approach that aimed to restructure one's thoughts while simultaneously perpetuating desirable behavior. The foundation of CBT is embedded in the notion that one may elicit cognitive activity mediating behavioral and affective change. The CBT model conceptualizes situations, thoughts, feelings, and behavior as being connected. It interrupts the cycle of automatic thoughts (evoked by a stimulus), replacing them with alternative thinking strategies that bring about behavior change. Consequently, the emphasis on cognitive mechanisms to create a change in behavior is what differentiates this from behavior therapy. As such, CBT refers to the class of interventions based on the basic premise that emotional disorders are maintained by cognitive factors, and that psychological treatment leads to changes in these factors through cognitive restructuring and behavioral techniques (e.g., exposure, behavioral experiments, relaxation training, social skills training) (Hoffman & Smits, 2008).

Beck (1976) posited that negative thoughts often represent a distorted perception of reality. Therefore, treatment aims to reduce the emotional impact of unpleasant cognitions by replacing them with more accurate and adaptive ones. As such, there are three fundamental propositions in CBT, (1) cognitive activity affects behavior, (2) cognitive activity may be monitored and altered, and (3) desired behavior change may be effected through cognitive change (Dobson & Dozois, 2010).

Distressing thoughts and emotions are common among psychiatric disorders characterized by negative affect, including depression, anxiety disorders, eating disorders, and psychosis (Yoval, Mor, & Shakarov, 2014). Specifically, CBT has been applied to an array of presenting concerns experienced by children and adolescents, including hyperactivity, aggression, and disruptive behaviors. A few CBT measurements of success include: academic outcomes, increases in social reasoning abilities, improved peer relationships, and maintenance of these changes. For children and adolescents, CBT focuses on schema development and the cognitive processes of automatic thoughts (Christner, Stewart, & Freeman, 2007). In this context, schemas are operationally defined as the way individuals view themselves, others, the world, events, and interactions. It is further posited that in younger children, their schemas are still developing (Wilson & Cottone, 2013).

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Negative external factors, such as an invalidating home environment, physical/verbal abuse, and exposure to violence, have been shown to have a negative impact on a child's perception of self, others, and the world (Shedler, 2010). Furthermore, ethnoracial factors, such as discrimination, colorism, racism, and ethnoviolence, most commonly experienced by African Americans, are factors that impact cognitions as early as age 3 (Clark & Clark, 1939; Jordan & Hernandez-Reif, 2009). With this information, a social-cultural division is delineated between the minority and majority experience, which may be a critical factor to consider in CBT effectiveness with African American youth.

The Research Gap

Empirically, CBT has been supported by numerous randomized controlled trials (RCTs) and individual case studies. CBT is demonstrated as the most efficacious treatment when compared to other treatment modalities such as, interpersonal therapy, acceptance and commitment therapy, treatment as usual, and a no treatment group at all (Segal, Vincent, & Levitt, 2002). An aggregate of CBT clinical outcome research findings have demonstrated robust treatment effectiveness for many disorders. Hoffman and Smits (2008) reviewed 1165 studies and identified 27 randomized placebo-controlled trials to estimate the efficacy of CBT compared to psychological or pharmacological placebo conditions for anxiety disorders, and to examine whether the number of treatment sessions and the placebo modality moderate treatment outcome. Findings pertaining to CBT efficacy have revealed medium to large effect sizes in reduction of anxiety disorder severity, and have demonstrated significantly greater benefits than placebo treatments (Hoffman & Smits, 2008). However, despite some recent improvements, research on the application of CBT with diverse populations continues to be scarce.

The majority of the studies examining the effectiveness of CBT were conducted predominantly with a non-Hispanic White middle-class population. It has been noted that there has been a lack of ethnic minority participants in psychological research (Wilson & Cottone, 2013), particularly in studies of anxiety disorders (Mendoza, Williams, Chapman, & Powers, 2012; Williams, Powers, Yun, & Foa, 2010). It is important to note that despite the underrepresentation of ethnic minorities in psychological research, there is an overrepresentation of research highlighting African American youth and disruptive disorders (Bird et al., 2001). This directly conflicts with the results from epidemiological psychological research studies that conclude that White Americans have higher conduct disorder prevalence rates than African Americans (Nock, Kazdin, Hiripi, & Kessler, 2006).

It is also essential to examine specific factors affecting findings among African American families and the cultural ingredients that facilitate successful outcomes. It is important to explore the effects of chronic environmental stress with regard to the effect it has on children, especially those facing numerous social, economic, and psychological stressors (Evans & Kim, 2013). As such, the purpose of this chapter is to review the literature pertaining to CBT among African American youth, incorporate the socio-historical context of the African American experience, identify existing culturally conscious CBT approaches that are effective with African American youth, explore factors contributing to attrition among African American youth, and to highlight the need for further research in this population.

Behavioral Interventions in African American Youth

Throughout the lifespan, African Americans struggle with the same mental disorders that afflict their European American counterparts. The National Survey of American Life (NSAL) examined anxiety disorders among African Americans, Blacks of Caribbean descent, and non-Hispanic Whites in the USA (Himle, Baser, Taylor, Campbell, & Jackson, 2009). Results indicated that although non-Hispanic Whites were at elevated risk for generalized anxiety disorder (GAD), panic disorder (PD), and social

phobia compared to Caribbean Blacks and African Americans, when Black respondents met criteria for an anxiety disorder, they experienced higher levels of overall mental illness severity and functional impairment compared to White respondents (Himle et al., 2009). Himle and colleagues also found that Black respondents had higher rates of post-traumatic stress disorder (PTSD) and suggest that increased exposure to high trauma environments and oppression explicate the elevated prevalence rates of PTSD in Black respondents. Thus, these results indicate a need for targeted treatment to remediate anxiety disorders among diverse groups, as greater severity and persistence of many disorders is evident among Black Americans.

Among African American youth, the National Household Survey on Drug Abuse (NHSDA) epidemiological study examined mental health conditions among a representative sample of diverse 12–17 year olds ($n = 19{,}430$) via in-home surveys to determine 12-month prevalence and comorbidity (Chen, Killeya-Jones, & Vega, 2005). They found that over half of African American youth met criteria for an anxiety disorder, 18.3 % had Attention Deficit/Hyperactivity Disorder (ADHD), 26.4 % had Oppositional Defiant Disorder (ODD), and 5.4 % struggled with a substance use disorder. African American youth reported more psychiatric symptom clusters overall than White and Hispanic youth, despite lower use of licit and illicit substances, with significantly higher rates of anxiety disorders (OR = 1.67). They also reported higher rates of comorbidity than any other ethnic group, and younger adolescents had a slightly higher rate of comorbidity than their older counterparts.

Angold et al. (2002) utilized a large rural sample of African American and European American youth ($n = 920$) from four North Carolina counties, with more than half the sample being comprised of primarily low-income African Americans ($n = 541$). Twenty-one percent of the African American sample had one or more DSM-IV diagnoses, yet only 3.2 % had utilized mental health services outside of the school system in the previous)3 months. Disruptive behavior disorders, such as ADHD, conduct disorder, and ODD, were more common than affective and anxiety disorders. Among the specific diagnoses, the most common were childhood-onset conduct disorder, anxiety disorders (primarily separation anxiety and social phobia), and substance use disorders. Thus, there is a compelling need for CBT treatments for African American youth.

Cognitive Behavioral Therapy in African American Youth

CBT for Anxiety and Trauma

Anxiety disorders are among the most common conditions affecting youth, with prevalence rates between 2 and 19 % (Costello, Egger, & Angold, 2005), and CBT remains the treatment of choice for such disorders. There is often an assumption that anxiety is a product of distorted/irrational beliefs about one's environment and/or internal processes, and so the identification of such perceptions is an important therapeutic target, depending on the age and the cognitive flexibility of the child. Given African American youth experiences with chronic prejudice, racism, differential access to resources, and documented disparities in how they are viewed and treated by authority figures (American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008), behavioral and emotional difficulties experienced by African Americans may be a result of lived experiences and/or socio-cultural factors that genuinely impact them over the life course (Chapman, DeLapp, & Williams, 2014). Such experiences can serve as a catalyst for development and expression of mental disorders in African Americans of all ages, and are not simply cognitive distortions that can be reframed through Socratic questioning. For example, racism at school, bullying from peers, and discrimination from teachers could contribute to problems such as social anxiety, agoraphobia, and school refusal. Thus, therapists must bring an understanding of collective African American experience with them when working with African American youth (Parham, 2002).

In addition to the ability to teach reasoning and thinking of alternative ways to solve a problem, CBT includes behavioral and physiological components (such as deep breathing, guided imagery, and progressive muscle relaxation) that teach youth relaxation strategies to manage unwanted physiological arousal, while also providing practice in utilizing adaptive behaviors during activities that simulate difficult situations (e.g., through in vivo/imaginal exposure, therapist modeling, and role playing) (Seligman & Ollendick, 2011). Programs can be implemented to address the cognitive, behavioral, and physiological components of psychological dysfunction when working with adolescents struggling from internalizing (e.g., anxiety and depression) symptomology (Fisak, Richard, & Mann, 2011). For example, a youth struggling with anxious arousal can practice identifying unwanted feelings (e.g., increased heart rate, nausea) and learn to implement relaxation techniques during situations that elicit these physiological reactions (Fisak et al., 2011). Indeed, mindfulness techniques have gained popularity in recent years and are being applied (often very successfully) to a variety of therapeutic treatment plans (Brown, Marquis, & Guiffrida, 2013). However, as mentioned previously, the existing literature regarding the application of CBT in African American children is sparse, resulting in gaps in knowledge about generalizability and effectiveness of such treatments for individuals of diverse backgrounds (Scheeringa, Weems, Cohen, Amaya-Jackson, & Guthrie, 2011; Schwartz, Radcliffe, & Barakat, 2007; Waldrop & de Arellano, 2004).

Kendall et al. (2008) conducted an RCT that examined CBT outcomes among African American children ages 7–14 ($n=14$) with an anxiety disorder, and found that family CBT was not superior to individual CBT. However, there were significant improvements in the reduction of anxiety. These findings regarding African American familial participation should be interpreted with caution due to the small sample of African Americans involved in the study. The findings are however important for our understanding of culturally acceptable approaches to the treatment of anxiety with African American youth and families. Findings from a study by Khanna and Kendall (2009) illustrated benefits in child global functioning by including parents in family CBT for child anxiety; there was an improvement in the child's overall functioning (but not the child's anxiety levels) when there was a parent-training component implemented.

Current literature indicates that group cognitive behavioral therapy (GCBT) is possibly efficacious for African American youth with anxiety disorders (Huey & Polo, 2008). GCBT involves the use of cognitive and behavioral strategies including exposure, self-control training, contingency management and contracting, peer modeling, and feedback. Although the sample size was small ($n=12$), Ginsburg and Drake (2002) found that anxious African American adolescents benefited from adapted GCBT and that adapted GCBT was superior to an attention control placebo. Specifically, for test anxiety in African American youth, anxiety management training, study skills training, and a combination of both (modified anxiety management training) meet criteria for efficacy in treatment (Huey & Polo, 2008).

LeSure-Lester (2002) was the first study to provide empirical evidence of CBT treatment with African Americans who were abused. Participants were of low SES and previously placed in group homes or with the local authority. Participants who received CBT demonstrated greater rates of behavior change from the pretest phase to the posttest phase. More specifically, trauma-focused cognitive-behavioral therapy (TF-CBT; Deblinger & Heflin, 1996) has been shown to be efficacious for trauma-exposed ethnic minority youth. TF-CBT is a structured, short-term parent and child-focused treatment involving psychoeducation, coping skills training, exposure, cognitive processing of the abuse experience, and parent management training.

One study examined the efficacy of TF-CBT in African American children between the ages 3 and 6 with PTSD (Scheeringa et al., 2011). Participants were living in New Orleans, largely of low education, and primarily with no fathers in the home. African American children accounted for 60 % of the sample size; unfortunately no demographic information on the SES of participants

were provided. The protocol consisted of 12 sessions and included graduated exposures to trauma-related reminders in three modalities (drawings, imaginal, and in vivo). Parental/caregiver involvement was also incorporated to build the parent–child bond, and the alliance between the therapist and child. Results indicated that TF-CBT was effective in reducing trauma-related symptoms. Of the 25 treatment completers, 17 had PTSD diagnosis pre-treatment and only 3 still had the diagnosis post-treatment, representing 82.4 % reduction (Scheeringa et al., 2011). This study suffered from high dropouts (64 were randomized), which is unfortunately common for PTSD treatments, and even more so among African Americans (Lester, Resick, Young-Xu, & Artz, 2010).

CBT for ADHD

The CBT paradigm has been successfully used to assist children ages as young as 3 years of age with hyperactivity, aggression, and disruptive behaviors. In older children it has been shown not only to significantly improve academic outcomes, increase social reasoning abilities; and improve peer relationships, but also to maintain these changes (Crawley, Podell, Beidas, Braswell, & Kendall, 2013).

A 10-year review highlighted significant findings for African American children with ADHD (Miller, Nigg, & Miller, 2009). The authors conducted a systematic search and identified 52 relevant empirical investigations. The pooled aggregated data revealed that ADHD behavior ratings (parent and teacher) evidenced higher scores for African American children compared to non-Hispanic Whites, but African American children were diagnosed with ADHD only two-thirds as often as White youth (Miller et al., 2009). Miller et al. speculated this could be due to a less structured and more active class environment, which results in higher levels of ADHD activity as rated by teachers. Another possibility is that African American youth exhibit more ADHD symptoms because they are exposed to more ADHD-related risk factors, such as low SES, exposure to environmental toxins, and maternal stress (Arnold et al., 2003; Grizenko et al., 2012). However, there was a lack of sufficient data to determine the contributing factors for the reported elevated ADHD symptoms among African American children, demonstrating the need for more research on this population.

Findings of other studies reported in the Miller et al. (2009) review mentioned efficacious ethnically and culturally sensitive methods to evaluate for psychopathology and comorbidity and treatment of ADHD in African American youth. For example, Samuel et al. (1998) utilized culturally adapted structured interviews administered by African American raters trained in cultural sensitivity and blind to child diagnosis. This was a middle-class sample consisting of 19 African American children with ADHD compared to 24 without. Results indicated a higher level of comorbidity with ODD, severe major depressive disorder, bipolar disorder, and separation anxiety in African American children with ADHD. Unfortunately, this was a small sample, and as previously stated, limited literature exists to explain the possible reasons for elevated comorbidity among African American children with ADHD.

One of the few studies exploring these issues and outcomes was the Multimodal Treatment Study for Children with Attention Deficit Hyperactivity Disorder (MTA), which was conducted by six independent research teams in collaboration with the National Institute of Mental Health and the US Department of Education. The MTA was a 14-month study designed to address questions about the individual and combined effects of pharmacological and psychosocial/behavioral treatment for children of ages 7–9 years with ADHD. This study represented a broad range of ADHD youth ($n = 579$), 20 % being African American (Arnold et al., 2004). The 14-month (end of treatment) intent-to-treat results showed that for ADHD and ODD symptoms, the expert MTA medication management, whether alone or in combination with behavioral treatment, was significantly superior to behavioral treatment alone and to routine community care—even though the community group received

similar medication from their community physician. The combination of expert medication management and behavioral treatment was not significantly better than the medication alone (MTA Cooperative Group, 1999). Though the practice parameters for the treatment of ADHD indicate that behavioral treatments may be used alone or in combination with medication, in most direct comparisons the efficacy of medication exceeded that of behavioral interventions alone. Conversely, for children ages 4–12, behavioral interventions had a moderate to large effect sizes compared with no treatment and compared with nondirective parent counseling and support (Murray, 2008).

Arnold et al. (2003) also examined the effects of race and ethnicity on treatment and outcome in the MTA study. Out of 579 boys with ADHD (mean age 8.5 years), 111 were African American. Unfortunately, no analysis of family SES was provided so we do not know the SES of the African American youth. Ethnic minority boys benefited significantly from combined treatment (medication and behavioral treatment), compared to medication treatment alone (Arnold et al., 2003). This finding was thought to be due to a preference among African Americans for a direct, structured therapeutic approach with clear, meaningful interventions. In addition, minority families were cooperative with the combined treatment interventions, indicating that the approach was acceptable and accessible, and therefore effective for use with those families.

Miller et al. (2009) speculated that African Americans might be uncomfortable with mental health interventions for problems like ADHD, due in part to misperceptions about the disorder, such as the notion that the child can simply stop the behaviors or the problems will improve on their own. African American parents are less likely to know where to go for help and are more likely to have negative expectations about the treatment process. Thus African American children may experience increased impairment from ADHD due to barriers to receiving treatment. Consequently, psychoeducational interventions may lead to greater treatment utilization among African American parents, caregivers, school employees, and community service providers with the implementation of community education on ADHD diagnosis and intervention as well as training and increased awareness of cultural issues (Miller et al., 2009).

CBT for Oppositional Behaviors and Conduct Disorder

Several RCTs of psychosocial interventions demonstrate that disruptive behavior disorders, including ODD and Conduct Disorder, respond well to behavioral interventions including many of the well-established parent management-training programs that focus on teaching parents behavioral strategies to reduce target behaviors such as temper tantrums, noncompliance, aggression, defiance, stealing, and destruction of property (Miranda et al., 2005). Juvenile delinquency occurs when minors participate in illegal behavior, and thus Conduct Disorder and its precursor ODD, are typically associated with delinquency. Although recent reviews point to several successful approaches for preventing juvenile delinquency, multisystemic therapy (MST) has been considered a treatment of choice to reduce criminal offending among African American youth (Miranda et al., 2005; Scherer, Brondino, Henggeler, Melton, & Hanley, 1994). MST is an intensive, family-focused, and community-based treatment program that includes CBT and pragmatic family therapies (Henggeler, Melton, Brondino, Scherer, & Hanley, 1997). Therapists visit youth and their families at home and in their communities to provide treatment where and when it is most needed and to increase generalizability of acquired skills. Additionally, the therapist is available around the clock, and sessions may occur daily. MST includes techniques derived from family therapy, behavioral parent training (BPT), and CBT. Finally, MST includes ongoing training and supervision to monitor treatment integrity. However, a recent meta-analysis of 22 studies found only small effects for MST in reducing delinquency, and it was actually least effective with ethnic minority clients (van der Stouwe, Asscher, Stams, Deković, & van der Laan, 2014). Clearly, more research is

needed to determine the best ways to help African American families struggling with the challenges of juvenile delinquency.

In addition to case studies examining the efficacy of CBT in African American children (e.g., Costigan, 2001), CBT has also been empirically demonstrated to reduce emotional, behavioral, and social difficulties and to increase adaptive school behaviors (Arnold et al., 2004). Specifically, several treatment modalities have been identified as effective for use with maladjusted children. An individual case presented by Waldrop and de Arellano (2004) assisted a 5 year-old African American male child with developing and practicing communicative skills utilizing offender-focused treatment. The authors describe the offender-focused treatment as an intervention that utilizes familial support to help the victim of a trauma face their perpetrator. Consequently, after 22 sessions of CBT and offender-focused therapy, the young child demonstrated a significant reduction in anxiety, depression, withdrawn behavior, thought problems, and PTSD arousal symptoms. He also became more behaviorally activated and exhibited more engagement with his peers. The authors posited that offender-focused treatments that include family support might be helpful for decreasing the risk for further abuse. The offender-focused treatment included familial support to encourage empowerment and to increase overall resilience to face the event and the perpetrator.

In another study, Boxer and Butkus (2005) used an intervention for an aggressive African American male adolescent by adapting standard techniques of CBT and incorporating social-cognitive targets. As a result, his problems and aggression did not reemerge over time and he began socializing appropriately with peers and his mother. Aggressive youth may struggle with their appraisal of social situations, for example, experiencing thoughts such as, *He bumped into me because he thinks that I am a punk*, and similar types of thinking can be a direct trigger for violent behaviors (Wilson & Cottone, 2013). An effective skills-based technique used to teach adolescents how to challenge such maladaptive beliefs is problem-solving skills training, which encourages the youth to evaluate internal and external cues influencing the situation prior to identifying an appropriate solution. Some studies have also illustrated greater use of coping skills when positive parenting is encouraged by the intervention (Wilson & Cottone, 2013).

Socio-Historical Context and Cultural Adaptations

Studies suggest that single parenthood and extended families continue to be more common among Blacks than among Whites. Vereen (2007) highlights that Black households are more likely to include extended family members, regardless of the immediate family unit, although the importance of extended family is often not addressed in research. The existing literature describes African American and other Black cultures as collectivistic/communal. Communalism emphasizes the importance of social bonds and responsibilities, reflects a sense of interdependence and preeminence of the collective well-being, and includes drive for connection within the group (American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008; Cokley, 2005). Among African American children, communalism, cultural capital, spirituality, and intergenerational transmission of wealth are protective factors mitigating the impact of their unique socio-cultural and political realities. It is important to understand the development of the African American child in the unique context of US society because it means factoring in the impact of lower SES, limited resources, and reduced access to education (for impoverished youth) and the impact of discrimination and racism, as these may contribute to dysfunction. Hence, identifying key features that mitigate these chronic experiences between low SES and underserved African Americans is warranted not only to conduct future research but to also inform clinical mental health practices.

Cokley (2005) maintained that understanding African American identity should focus on principles rooted in an Afrocentric worldview that

critically examines and affirms African cultural values (also referred to as Afrocentric values) as the foundation of African American identity and culture (Akbar, 1989; Cokley, 2002; Hilliard, 1997; Nobles, 1989). This includes an emphasis on spirituality (i.e., emphasis on "being spirit" rather than just practicing religion; Grills, 2002), collectivism (i.e., priority to the goals of family and the group; shaping behavior based on family and African American norms and duties; interdependence; Triandis, 2001), communalism (i.e., emphasis on relationships; recognition of every community member's value and uniqueness; unity without uniformity; Gordon, 2002), and belief in self-knowledge as the basis of all knowledge (Myers, 1988; Parham, 2002). It is worth noting such values are not exclusive to people of African descent and can be held by people of various ethnic groups and cultures throughout the world. Some have posited that these values, constitute an optimal worldview (Myers, 1988), therefore, understanding the cultural values of the African American family is paramount to understanding the origin, dynamic, and manifestation of mental health concerns. Such an understanding will provide further insight into culturally sensitive implications for treatment.

Moreover, Black Americans are a heterogeneous group and do not all share the same worldviews. Differences in SES and acculturation will result in differences in worldview, and consequently the presentation of mental disorders and effectiveness of treatment. Highly acculturated families will respond better to treatments developed on European Americans than their less acculturated counterparts (Carter, Sbrocco, & Carter, 1996). Additionally, immigrant and foreign-born Blacks (e.g., Caribbean Americans, Ethiopian Americans) will differ in their historical and cultural understanding of the US experience, as the legacy of colonialism affects each group differently. As a result, foreign-born Blacks may have a different perspective on oppression, White privilege, and associated outcomes in youth (American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008).

Although much of our current knowledge of child and adolescent mental health and illness is derived from research conducted largely with middle-class European American youth (American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008), in recent years, a strong body of research has emerged that has assisted in creating a knowledge base of culturally sensitive components that can be incorporated into CBT. Of note, Schwartz et al. (2007) reported culturally sensitive components to consider when working with African American youth and their families. These recommendations were developed as part of an RCT that examined African American children between ages 12 and 18 with a sickle cell disorder ($n = 58$). Each intervention involved home-based sessions that included CBT components of pain management such as relaxation, deep breathing, guided imagery, and positive self-statements. Both the adolescent and a family support person were asked to practice treatment components together in between sessions (Schwartz et al., 2007).

To identify components of the intervention necessary to improve its cultural sensitivity and effectiveness, a review of literature describing issues of cultural competence in interventions with African Americans was conducted. Ten culturally sensitive components for treatment were identified: inclusion of families, emphasis on empowerment, acknowledgement of stress related to minority status, identification of stress-related SES (including limited resources or barriers faced by African Americans who have achieved economic success), culturally sensitive content, awareness of stigma surrounding mental health problems, mistrust of research, availability of community or home-based intervention, flexible scheduling, and training in cultural sensitivity for treatment providers (Schwartz et al., 2007). Although there were challenges regarding staff size, time commitment, and safety, the results indicated that the home-based training was effective in terms of treatment completion. Other studies have highlighted the importance of many of these elements as well (Williams, Tellawi, Wetterneck, & Chapman, 2013).

Similarly, BPT for children with externalizing problems may be an effective approach for African American youth (e.g., Erhardt & Baker, 1990), as it resonates with the collectiveness of the African American culture. Studies of BPT have typically examined group-based interventions consisting of 8–16 sessions in which parents are taught to implement behavior modification techniques through modeling, discussion, role playing, and home practice (Murray, 2008). These techniques are rooted in the principle of CBT principles and include; (a) identifying and monitoring behaviors, (b) providing positive attention, (c) ignoring minor inappropriate behaviors, (d) implementing formal reward systems, and (e) administering consequences. Parents receive a psychoeducation intervention that teaches them the techniques that were administered to their child. The parent observes the child via live video recording and is simultaneously instructed by the clinician on how to implement the techniques. This approach supported parental acquisition of the skills needed to reinforce treatment outside of the therapeutic setting, and assisted the clinician in assessing whether the parent was able to understand the child's behavioral expressions. In addition, the parent-training components also enhanced the therapist–client therapeutic alliance. BPT has illustrated large improvements in parent ratings of problem behaviors and observed negative parent and child behaviors, and can be further enhanced for minorities by the inclusion of culturally similar examples. Child compliance rates, aggression, perceived severity of ADHD symptoms, parent management skills, and parenting stress also show improvement as a result of BPT interventions (Murray, 2008). Therefore such interventions may be especially well-suited for African Americans as they empower the family to work together effectively.

Schwartz et al. (2007) mentioned the importance of recognizing stress related to ethnic minority status. Key CBT treatment ingredients to manage stress are relaxation exercises (i.e., focusing on the breath), gradual exposure to fear hierarchies to habituate extinguishing fear, frequent and consistent practice of replacement behaviors and thought monitoring. Utilizing the guided imagery technique, participants choose imagery to promote cultural consonance, including active and exciting events like sports or familiar settings; music may be incorporated into guided imagery (Schwartz et al., 2007). In addition, progressive muscle relaxation is another technique that has demonstrated successful outcomes in African American youth (Schwartz et al., 2007).

Recent research has indicated that musical interventions can be successfully incorporated into CBT for African Americans. For example, two exercises developed by Neal-Barnett et al. (2011) use music and a call-response method, prevalent in some African American communities, as a form of cognitive restructuring for women with anxiety. The *So What Chorus* and the *Build Your Own Theme Song (BYOTS)* are part of a musical intervention for decreasing anxiety symptoms in members of the Sister Circle, an intimate group therapy setting for African American women. Culturally relevant musical CBT interventions have likewise been used to address mental health concerns in racially diverse children (Fitzgibbon et al., 2005, 2011).

The Importance of Promoting Positive Ethnoracial Identity

Ethnoracial identity consists of a sense of commitment and belonging to an ethnic/racial group, positive feelings about the group, and behaviors that indicate involvement within the group (Avery, Tonidandel, Thomas, Johnson, & Mack, 2007; Robert et al., 1999). Positive ethnoracial identity is a sense of self, which has been demonstrated to be a protective factor related to identity development among African Americans and other people of color. Positive ethnic and racial identities are essential to the personal and collective well-being and resiliency of African American youth (American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008). Most research on psychological correlates of ethnoracial identity has focused on youth because the process of developing an ethnoracial

identity is thought to typically begin childhood. Among adolescents, positive identity has been found to be associated with self-esteem, coping, sense of mastery, and optimism; conversely, loneliness and depression have been negatively related to ethnoracial identity (Robert et al., 1999). In adults, positive ethnoracial identity has been associated with self-esteem and reduced anxiety and depression (Lorenzo-Hernandez & Ouelelette, 1998; Williams, Chapman, Wong, & Turkheimer, 2012). Negative ethnoracial identity in African Americans has been linked to poor self-esteem, problems with adjustment, poor school achievement and dropout, delinquency, eating disorders, and substance abuse (Rivas-Drake et al., 2014; Vandiver, 2001).

Consequently, research has identified racial socialization as a protective factor. African American families are instrumental in the process of racial socialization by transmitting values, beliefs, and ideas based on cultural knowledge of the competencies needed for optimal functioning as a stigmatized minority in society (American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008). Racial socialization influences children's identity and self-concept, beliefs about the world, strategies and skills for coping with and navigating racism, and inter- and cross-racial relationships and interactions (Lesane-Brown, Brown, Caldwell, & Sellers, 2005). African American children who learn that others may think negatively of them in concert with values, beliefs, and knowledge of a positive racial identity are less likely to have negative outcomes and more likely to be resilient in adverse conditions (American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents, 2008). Finally, an emphasis on empowerment is essential in acknowledging social, emotional, and cultural strengths, encouraging self-advocacy, bolstering racial pride, and supporting spirituality (Cokley, 2005; Schwartz et al., 2007).

Thus clinicians should routinely assess and consider the client's stage of ethnoracial identity development when working with African Americans, especially youth. This might occur in the form of clinicians encouraging and supporting African American clients in the exploration of their ethnoracial identities to help improve overall psychological well-being. CBT interventions might include discussions of what the client likes about African Americans, learning more about Black history and the achievements of African Americans, explicit rejection of pathological stereotypes, and increased involvement in traditional cultural activities to build a greater sense of ethnoracial pride (Williams, Chapman, et al., 2012; Williams, Gooden, & Davis, 2012). Additionally, the American Psychological Association, APA Task Force on Resilience and Strength in Black Children and Adolescents (2008) noted that critical-mindedness could help protect against the damage experiences of discrimination can cause and facilitate a critique of existing dysfunctional social conditions. Understanding cultural differences can promote flexibility and give one the tools to adapt to the difficult cognitive, emotional, and social situational demands that today's minority youth must often traverse.

Treatment Attrition among African American Youth

Attrition is a significant problem in the evaluation and delivery of mental health care for African American youth (Gonzalez, Weersing, Warnick, Scahill, & Woolston, 2011). Individuals from ethnic minority groups are less likely to initiate mental health treatment and more likely to end treatment prematurely (Gonzalez et al., 2011; Waldrop & de Arellano, 2004). Attrition for children and adolescents may depend heavily on parent and family factors (i.e., finances, insurance coverage, cultural mistrust). Additionally, several factors have been identified that may contribute to low engagement and poor retention in therapy, including a perception 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) may impact attrition rates. 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 does not evaporate the moment the patient walks out of the therapist's office.

In concert, research postulates explanations for engagement of African American families and completion of treatment. Noting that external and complex stressors account for a large part of the lack of engagement in treatment, research suggests that African American families may believe treatment is of low value (McNeil, Capage, & Bennett, 2002; Neal-Barnett, 1996). For example, African Americans have different parental values than European Americans, and thus, it is likely that African Americans may not find the same treatment efficacious (Capage, Bennett, & McNeil, 2001; Forehand & Kotchick, 1996). Thus when African American families illustrate lower participation rates in treatment, clinicians should consider the perceived value of the treatment. Capage et al., (2001) identified parental stress as a factor accounting for 65 % of the variance that predicted African American's drop-out rates. The study concluded that clinicians should use assessment tools (i.e., Parental Stress Indicator) to identify parental stressors that may impede successful treatment completion.

Other factors suspected of negatively impacting mental health service use and perceptions among African Americans include cultural mistrust, historical and current medical and research abuses (Suite, La Bril, Primm, & Harrison-Ross, 2007). Cultural mistrust, decreased help-seeking behaviors, and lower participation in treatment have been hypothesized as being related to historical events such as the US Public Health Service Syphilis Study at Tuskegee (1932–1972) and more recent publicized abuses such as the Johns Hopkins Lead Paint Study (Gamble, 1997; Spriggs, 2004; US Department of Health and Human Services (USDHHS), 2001). These are just a few events that may account for the cultural mistrust and stigma associated with higher African Americans attrition rates. Other contributing factors are the scarce number of culturally competent and minority mental health practitioners. According to the U.S. Department of Labor (2012), only 5.3 % of physicians, 5.1 % of psychologists, and 18.7 % of counselors are African American. This can make it difficult to connect with ethnically similar mental health providers and contribute to the notion that mental health care is not relevant to African Americans.

Conclusion

The foundation of CBT is embedded in the notion that changing cognitive activity and behaviors can bring about affective change. CBT has been demonstrated to be the most effective treatment for many disorders when compared to other treatment modalities (Segal et al., 2002). Given the slow emergence of empirically sound research studies with meaningful numbers of African American youth, there remains a paucity of culturally sensitive mental health treatment interventions. A few studies have noted that parent/caregiver training is efficacious for African American youth given their familial values rooted in communalism and extended kinship support networks. Adaptations discussed included parental involvement/family-based intervention, empowerment utilizing familial support, understanding the impact of racism, and facilitating positive ethnoracial identity development.

Further investigative research is also needed as treatment attendance and outcome are affected by stress related to ethnic minority status, stigma associated with mental health problems, and mistrust of mental health providers. Treatments with culture-specific modifications can perhaps improve the quality of mental health care services available to underserved populations by increasing the credibility of treatment interventions (Waldrop & de Arellano, 2004; Williams et al., 2014). Thus, further examination of African American values is needed to continue to inform the research body and the emerging and existing treatment modalities.

As noted by Sayers and Heyman (2003), CBT is ideal in many ways for African American families and youth due to the empowering nature of this approach and its focus on building strengths and achieving goals. Furthermore, the collaborative nature of CBT may be ideal for African American youth, since the therapist is characterized as the expert in the approach while the youth is viewed as an expert of herself (Kelly, 2006). Insomuch as the evidence indicates that CBT is effective for African Americans, the increased provision of CBT interventions in communities, schools, homes, and even churches could help to expand access to these services (Ginsburg & Drake, 2002; Queener & Martin, 2001). Finally, ongoing training of clinicians in cultural sensitivity, and inclusion of culturally sensitive content into empirically supported interventions remains a priority (Williams, Tellawi, et al., 2013).

Future Directions

More research is needed (i.e., RCTs, longitudinal, experimental studies, and treatment outcome studies) for African Americans in general and especially for African American youth. More empirical studies are imperative as a means to evaluate the efficacy of a treatment. Future studies should examine attrition rates with shorter CBT sessions that focus on the most immediate client concerns. In addition, more culturally sensitive psychologists and psychologists of color are needed to implement such studies. Increased funding (i.e., scholarships, grants for research) for African American psychologists and funding for more training in cultural competency for all mental health providers would help greatly in reducing stigma and other barriers to care (Cryder, Kilmer, Tedeschi, & Calhoun, 2006).

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