Cultural Competence in Therapy with African Americans

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African Americans face unique challenges in the mental health care system. For instance, African Americans with mental health problems are more likely than European Americans to be misdiagnosed or undiagnosed (Schwartz & Feisthamel, 2009). They are less likely to receive specialty mental health care (e.g., psychologist, psychiatrist; Alegría et al., 2002; Alegría, Carson, Goncalves, & Keefe, 2011), and are more likely to be treated in primary care or community clinic settings (Noël & Whaley, 2012), where outcomes are sometimes worse for ethnic minority clients (Borowsky et al., 2001; Weersing & Weisz, 2002). When they do receive treatment, they are less likely to receive adequate care (Hahm, Cook, Ault-Brutus, & Alegría, 2015), and are more likely to end treatment prematurely (Fortuna, Alegría, & Gao, 2010; Smith & Trimble, 2016). The U.S. Department of Health and Human Services (2001) concluded that African Americans and Whites tend to have similar rates of psychiatric disorders, but that African Americans experience a greater burden of disease as a result of some of the disparities mentioned above.

The causes for these disparities are multifaceted and cannot be readily distilled to any single cause (Smedley, Stith, & Nelson, 2003). Disproportionate experiences of poverty, incarceration, racism, and exclusion, likely intersect with the mental health needs of African Americans and may contribute to disparities (R. Williams & Williams-Morris, 2000; Roberts, 2003; Simons et al., 2002; Skiba et al., 2011; Snowden, 2014). At the same time, clinical factors and considerations such as clinical bias in assessment and treatment, misdiagnosis, lower rates of treatment engagement, and lower quality of services also likely contribute to observed disparities (DHHS, 2001; Snowden, 2003; Snowden, 2012). Further highlighting the complexity of these disparities is research showing that even when relevant sociodemographic variables are

controlled for (e.g., socioeconomic status, insurance status), racial disparities in treatment utilization and dropout persist (Alegría et al., 2002; Fortuna et al., 2010; Snowden, 1999).

Regardless of the exact causes, the consistent documentation of such disparities has led many mental health experts to conclude that culturally sensitive interventions – treatments that account for values, norms, attitudes, beliefs, and practices of a racial or ethnic group (Resnicow, Baranowski, Ahluwalia, & Braithwaite, 1999) – are necessary to increase engagement (e.g., utilization, treatment adherence) among African Americans in therapy and improve treatment outcomes. The increased emphasis on culturally responsive interventions has primarily focused on primary care and outpatient community treatment settings where African Americans are more likely to receive treatment and disparities have been observed.

In this chapter we critically assess the assumption that culturally tailored interventions are necessary to enhance treatment effects with African Americans. Specifically, we address three primary questions regarding the nexus between cultural competence and psychotherapy outcomes with African American youth and adults. First, is psychotherapy effective at reducing mental health problems with African Americans, and are there ethnic and racial differences in treatment outcomes? Second, what approaches to cultural tailoring are used with African Americans, and is there evidence that African Americans benefit from such approaches? Third, given the current evidence base, what are promising ways to think about improving treatment, including culturally tailored approaches, for African Americans?

Because we favor research that incorporates strong methodological rigor (i.e., internal validity) and robust patterns across the literature, we rely heavily on randomized controlled trials (RCTs) and meta-analytic reviews when possible. RCTs are considered the "gold standard" for assessing clinical efficacy because they involve random assignment of participants to treatment

conditions, and allow researchers to make causal inferences regarding treatment effects (APA, 2002). Meta-analyses involve synthesizing treatment outcomes across multiple studies with heterogeneous designs while controlling for specific study characteristics, and provide more precise and reliable measures of treatment effects than individual studies alone (Cohn & Becker, 2003; Westen, Novotny, & Thompson-Brenner, 2004).

Overview of Psychotherapy Effects with African Americans

Psychotherapy is a form of treatment for mental health problems that typically involves a therapeutic relationship between a clinician and client in which the clinician attempts to reduce the distress of the client through inducing changes in the client's feelings, attitudes, and behavior (Frank & Frank, 1993). The clinician may do this through verbal dialogue or prescribed written (e.g., thought record, trauma narrative, expressive writing) or behavioral assignments (e.g., deep breathing, exposure exercises). Many therapies involve a variety of treatment techniques and one of the most common types of therapy, cognitive-behavioral therapy, includes a focus on both in-session dialogue between the therapist and client, and prescribes between-session homework assignments (Beck, 2011). Therapy can occur in a variety of settings including primary care, community-based clinics, university-based research clinics, college counseling centers, inpatient or hospital settings, addiction treatment centers, private practice settings, client's homes, and prisons among others. Most of the literature on psychotherapy has focused on treatment delivered in university and community-based settings.

Literature reviews of psychotherapy outcomes for African Americans are cautiously positive, particularly those focused on youth. Huey and Polo (2008) found numerous evidence-based treatments (EBTs) for African American youth with conduct problems (e.g., cognitive-behavioral treatment; multisystemic therapy [MST]), and fewer for other psychosocial problems

including test anxiety (e.g., anxiety-management training), ADHD (e.g., behavioral therapy combined with stimulant medications), suicidality (e.g., MST), and trauma-related problems (e.g., Resilient Peer Training). Effects sizes were in the low-medium range on average for studies using African American samples (d = .35)[1].

Reviews of psychotherapy outcomes for African American adults generally support its effectiveness. Carter and colleagues (2012) reviewed 14 studies of psychosocial treatments for African Americans with anxiety disorders including panic disorder with agoraphobia, posttraumatic stress disorder (PTSD), obsessive-compulsive disorder (OCD), and social phobia. Although only three RCTs were included in their review, each found positive treatment effects. Horrell's (2008) review focused broadly on cognitive-behavioral therapy (CBT) for ethnic minority adults, and summarized four RCTs addressing outcomes specifically for Africans Americans. Those four trials provide support that CBT is effective for African Americans with depression, PTSD, panic disorder with agoraphobia, and substance abuse.

Taken together, the available literature indicates that psychosocial interventions, including those without explicit cultural tailoring, work with African American adolescents and adults (see Table 1 for list of EBTs with African Americans). However, gaps in the literature remain (Huey, Tilley, Jones, & Smith, 2014), including the near absence of African American clients in some treatment areas (e.g., OCD; Williams, Powers, Yun, & Foa, 2010). Additionally, questions remain regarding whether there are racial/ethnic disparities in treatment outcomes. In other words, is psychotherapy as effective for African Americans as European Americans?

[1] Cohen's *d* is the most common effect size estimate used for clinical trials. It represents the standardized mean difference in outcomes between treatment and comparison conditions. Cohen (1988) considered a *d* of .2 as small effect, .5 as medium effect, and .8 as a large effect.

Are treatment effects similar across ethnic groups? To assess whether treatment is equally effective (ethnic invariance) or less effective (ethnic disparity) for African Americans compared with European Americans, we summarized reviews that compared treatment outcomes for these two ethnic groups. Research on youth-focused treatments (i.e., those aimed at clients 18-years-old or younger or their parents), generally found that there no reliable differences in treatment outcomes by ethnicity, with a few caveats. Huey and Jones (2013) summarized findings from five meta-analyses of treatment outcomes with youth and adolescents and found no consistent differences by ethnicity; however, these studies examined treatment outcomes for European American youth compared with ethnic minority youth and did not explore effects for African Americans specifically. Huey and Polo's (2008) review reflected a similar finding – three studies showed superior treatment outcomes for African Americans compared with European Americans, one study found superior outcomes for European Americans compared with African Americans, and seven found no significant ethnic differences.

For adults, the picture is also mixed, with most studies finding no significant differences in treatment outcomes by ethnicity. Of the RCTs in the Horrell (2008) review that involved comparisons of multiple ethnic groups, two studies found no differences in outcomes by ethnicity, while one found weaker effects for African Americans receiving CBT compared to European Americans. Analyses of ethnic differences in the two relevant RCTs in the Carter et al. (2012) review found equal benefit for both European Americans and African Americans. Reviews of adult treatments in Huey et al. (2014) also suggest that treatment effects are fairly robust across ethnic groups, and that, on average, psychotherapy is as effective with European Americans as ethnic minorities. In other words, there was no consistent evidence that European Americans benefited more from treatment compared with African Americans, and treatment was

effective with African Americans for the most common types of mental health problems (e.g., depression, anxiety, and substance use).

In summary, the results of treatment outcome studies generally support ethnic invariance in psychotherapy outcomes with three noteworthy limitations. First, there still exist areas for which positive psychotherapy effects with African Americans have not been sufficiently documented (e.g., OCD). Second, many studies lacked large enough samples of African American clients to adequately test whether treatment was as effective for African Americans specifically, and instead compared treatment effects between European Americans and ethnically mixed samples (i.e., treatment outcomes for all ethnic minority participants were combined into one comparison group). Third, the reviewed literature mostly involves clinical "efficacy studies" as opposed to "effectiveness studies." Efficacy studies generally take place in well controlled research environments (e.g., university clinics), and do not necessarily reflect outcomes in real-world practice settings (e.g., community mental health clinics) where African Americans are disproportionately likely to be treated (Snowden, 2014). Although it seems reasonable to conclude that African Americans stand to benefit as much from psychotherapy as European Americans, persistent evidence of disparities in treatment utilization and dropout continue to raise questions about how psychotherapy might be improved for this population, and whether culturally tailored treatments are necessary to reduce these disparities.

Cultural Competence Approaches, Models, and Evidence

Proponents of cultural competence differ in how they define this term, but tend to agree that it involves having a broad awareness of culture and the knowledge and skills to effectively treat racially and ethnically diverse clients (Sue, Zane, Hall, & Berger, 2009). Calls for increased attention to cultural diversity in the design, evaluation, and provision of mental health treatments

began in the mid-1980s and culminated in the publication of the APA's *Guidelines for Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists* (APA, 2003). The guidelines assert that all individuals have a cultural heritage that influences their worldview and that psychologists should strive to increase their knowledge and awareness of their own cultural heritage, assumptions, and biases. Psychologists are also encouraged to become knowledgeable about other cultures and to use culturally sensitive approaches in treatment (APA, 2003). The rationale for increased attention to culture in the delivery of mental health services is due to four primary concerns: 1) rapid sociodemographic changes in the U.S. population toward more ethnic diversity (Rastogi, Johnson, Hoeffel, & Drewery, 2011); 2) a historical lack of inclusion of ethnically diverse participants in research studies that constituted the empirical foundation of evidence-based treatments (Mak, Law, Alvidrez, & Perez-Stable, 2007); 3) evidence of ethnic/racial disparities in treatment utilization and dropout (DHHS, 2001; Snowden, 2012); and 4) concerns that traditional evidence-based approaches were Eurocentric, based on Western values and assumptions, and fail to accommodate the worldviews of culturally diverse clients (Gone, 2011; Kirmayer, 2012; Wendt & Gone, 2012).

Despite the rationale for increased emphasis on cultural competence, scholars continue to debate how this elusive concept should be understood and practiced, as there are no established standards to determine whether a provider, intervention, or treatment facility is culturally competent. Critics of cultural competence have warned that it may lead to overly simplistic attributions and stereotypical assumptions of cultural differences based on race and ethnicity, and risks viewing these factors as the most salient and important factor in clients' treatment (Satel & Foster, 1999; Weinrach & Thomas, 2004). In theory, a focus on cultural competence involves

considering numerous facets of client diversity including gender identification, age, sexual orientation/identity, socioeconomic status, disability, language, religious/spiritual beliefs, national origin, immigration status, level of acculturation, educational attainment, and historical life experiences (Whaley & Davis, 2007). However, in practice, researchers continue to struggle with how to account for and integrate the multitude of client diversity factors in treatment, and many have used ethnicity/race as the primary factor around which to organize the development of culturally sensitive approaches. Overall, it appears that cultural competence advocates and researchers continue to grapple with how best to broaden providers' awareness and attention to cultural differences in treatment, while minimizing the likelihood of providers inadvertently stereotyping clients or making treatment recommendations based solely on client race/ethnicity.

Some oft-recommended strategies when treating African Americans. Because there has been limited empirical attention to treatment strategies specific to African Americans, many clinicians have referred to recommendations of scholars who treat African Americans to increase their own cultural competence. There appears to be general agreement regarding the importance of several key themes in working with African American clients including openness to addressing experiences of racism, supporting positive racial-ethnic identity development, and incorporating clients' spiritual and/or religious values into treatment (Bean, Perry, & Bedell, 2002). Racism continues to be a particularly salient issue for African Americans, who report greater experiences of discrimination than other ethnic minority groups (Pieterse, Todd, Neville, & Carter, 2012). Such experiences are associated with increased psychological distress and poorer psychological functioning (Pieterse et al., 2012), and thus could be an important area for clinicians to develop competency in discussing with African American clients (APA, 2003; Boyd-Franklin, 1989). Similarly, working to support a positive racial-ethnic identity may also be

valuable with some African American clients, who in addition to reporting more perceived racism, are regularly confronted with negative stereotypes about their race (Johnson-Ahorlu, 2013). Indeed, research shows that a positive racial-ethnic identity is associated with several important outcomes for African Americans including self-esteem, well-being, psychological functioning, and academic adjustment (Rivas-Drake et al., 2014; Smith & Silva, 2011). Lastly, African Americans endorse greater levels of religious and spiritual engagement compared with other ethnic groups, and many African Americans turn to religious leaders and institutions (e.g., church homes) for support regarding mental health concerns (Boyd-Franklin, 2010). Carefully assessing and incorporating African Americans' religious and spiritual values into treatment where appropriate could serve to make treatment more relevant and engaging for some African American clients.

It is important to note that although evidence exists supporting the relevance of these issues with African Americans, findings are largely correlational, and empirical support demonstrating that treatment outcomes of providers who explicitly target these issues are superior to those who do not is still forthcoming. Hence, we recommend that clinicians use caution when implementing these recommendations, and that treatment approaches with African Americans avoid overgeneralizing and assuming these themes are relevant to all African American clients.

Culturally adapted treatment effects. Much of the empirical literature on improving mental health services for African Americans has involved culturally adapting or tailoring treatment (Huey et al., 2014). Typically, cultural adaptations involve systematic modifications to preexisting treatments aimed at making them more congruent with the cultural values, beliefs, attitudes, and practices of African Americans (Huey et al., 2014; Metzger, Cooper, Zarrett, &

Flory, 2013). In a recent review of culturally adapted interventions, Huey and colleagues (2014) summarized outcomes from five meta-analyses that reported treatment outcomes specific to African Americans (Griner & Smith, 2006; Hodge, Jackson, & Vaughn, 2012; Huey & Polo, 2008; Jackson, Hodge, & Vaughn, 2010; Smith, Rodriguez, & Bernal, 2011). For African Americans, interventions generally yielded effects in the small-to-medium range relative to control conditions, which were comparable to those of culturally adapted treatments for other ethnic groups.

Although not specific to African Americans per se, there is some evidence to suggest that culturally adapted treatment may be beneficial relative to standard treatment approaches. First, a meta-analysis by Benish and colleagues (2011) included only those studies comparing adapted treatments to other bonafide treatments (i.e., established treatment approaches), and found that adapted treatment was superior (d = .32). Second, in a recent meta-analysis of culturally adapted prevention and intervention studies, Hall and colleagues (2016) found that adapted treatment was superior to unapdated versions of the same intervention (g = .52). Two limitations to these meta-analytic findings are 1) they were not exclusive to African Americans and included culturally adapted treatment studies directed mostly toward other ethnic minority groups; and 2) they did not control for therapist allegiance effects, a phenomenon in which the treatment condition that the researcher favors (i.e., the culturally adapted treatment condition) may result in better outcomes due to researcher bias (Munder, Gerger, Trelle, & Barth, 2011).

Overall, meta-analytic results support the claim that culturally tailored approaches are more effective than control conditions at helping African Americans with a wide array of mental health concerns (e.g., depression, anxiety, trauma, substance use problems). Moreover, two meta-analyses with predominantly Asian American and Latino clients suggest that culturally

tailored approaches may be more effective than alternative treatments at ameliorating mental health symptoms (Benish et al., 2011; Hall et al., 2016).

Types of cultural tailoring with African Americans. Two common approaches for tailoring treatment for African Americans involve the use of Afrocentric models and client-therapist ethnic matching. Afrocentric frameworks seek to infuse intervention curricula with Afrocentric values (Cokley, 2005), and often include didactics that draw on the shared cultural history and experiences of African Americans (Belgrave, Chase-Vaughn, Gray, Addison, & Cherry, 2000). These models often aim to empower African Americans by addressing experiences of internalized racism, supporting a positive racial identity, fostering social cohesion and support among group members, and incorporating spiritual and faith-based coping strategies (Banks, Hogue, Timberlake, & Liddle, 1996; Davis et al., 2009). Treatments that utilize Afrocentric approaches are typically group-based, gender-specific, and limited to clients of African American heritage (Belgrave et al., 2000; Kohn, Oden, Muñoz, Robinson, & Leavitt, 2002).

One exemplar of the Afrocentric approach is the Claiming Your Connections (CYC) intervention. CYC is a strength-based, group intervention for Black women aimed at decreasing symptoms of depression while enhancing psychosocial competence (Jones, 2009). Intervention didactics focus on building healthy relationships, increasing social support, and fostering a positive Black female identity. The program is unique in its inclusion of literary works by Black women (e.g., bell hooks) as a tool to address issues specific to these women's psychosocial environment. The literary works are believed to augment group processes by allowing Black women to identify and discuss important themes relevant to their own lives, identify positive role models, and promote a positive Black female concept. In a randomized trial, CYC was found to

be effective at decreasing depressive symptoms and perceived stress compared to wait-list control (Jones & Warner, 2011). However, an important limitation is that CYC was not compared to a standard EBT or to a culturally "inert" but otherwise equivalent treatment, so it is unclear whether the cultural elements per se contribute to treatment efficacy.

Perhaps the most common approach to cultural tailoring involves the use of client-therapist ethnic matching. Some argue that this approach may be particularly useful with African Americans because of their shared history of discrimination, marginalization, and abuse, including by health service providers (Washington, 2006). Indeed, research shows that many African Americans report a cultural mistrust of European Americans (Benkert, Peters, Clark, & Keves-Foster, 2006; Townes, Chavez-Korell, & Cunningham, 2009; Whaley, 2001). For these reasons, use of client-therapist ethnic matching has been advocated as a way to increase rapport with African American clients, reduce attrition, and improve outcomes. In a meta-analysis of ethnic matching effects, Cabral and Smith (2011) found that, compared to other ethnic groups (i.e., Asian Americans, Latinos, and European Americans), African Americans indicated the strongest preference for seeing a provider of their same race (d = .88). Moreover, those who were ethnically matched viewed their therapists more positively than those matched with a therapist of a different ethnicity (d = .59), and experienced significantly better outcomes compared with those who were not ethnically matched, although the effect was small (d = .19). The finding that ethnic matching was associated with improved treatment outcomes (e.g., reduced symptoms of anxiety/depression) was unique to African American clients and was not found for Asian Americans, Latinos, or European Americans.

Why might ethnic matching be associated with better outcomes for African American clients? Some research suggests that African American clients who are ethnically matched may

be more inclined to disclose information that they might not otherwise disclose if seeing a provider of a different ethnicity. Ibaraki and Hall (2014) found that African American clients who were ethnically matched were 10 times more likely than unmatched clients to discuss substance use problems, and also more likely to attend three more treatment sessions. Samples et al. (2014) found that African American women who were interviewed by a same race provider, as opposed to a European American provider, reported higher levels of daily stressors and were more likely to disclose experiences of intimate partner violence. These findings suggest that for some African American clients, ethnic matching may increase client-therapist rapport and lead to discussion of more vulnerable content that they might not otherwise share, perhaps due to cultural mistrust, experiences of discrimination, or stereotype threat (Abdou & Fingerhut, 2014; Whaley, 2001).

However, a major limitation is that nearly all ethnic matching studies are correlational in design, leaving open the possibility that ethnic matching effects might be spurious or accounted for by other factors. Indeed, the one experimental study we know of with symptomatic African Americans found ethnic matching effects that were counterintuitive in nature. Genshaft and Hirt (1979) assigned impulsive African American and European American youth to self-control training led by either a Black or White peer model. Unexpectedly, both European American *and* African American youth showed the greatest improvement in self-control responses when assigned to White models. This rare experimental study of ethnic matching suggests that ethnic matching may not always be beneficial for African Americans. One possibility is that ethnic matching more often benefits those African Americans who report a cultural mistrust of European Americans, or who express a strong preference for an African American therapist (Townes et al., 2009).

Can cultural tailoring be harmful? Many cultural adaptations reported in the literature are theoretically-grounded, but most lack the rigorous empirical testing needed to validate their efficacy relative to culturally unadapted treatments (Huey et al., 2014). This can present a challenge to improving treatments for African Americans because adaptations that are intuitively appealing may not in fact be more effective; some may even yield poorer outcomes for African Americans. In contrast, some standard EBTs that appear minimally relevant to culture may result in better outcomes. Three recent studies evaluating culturally adapted interventions for African Americans illustrate these concerns. First, Kliewer and colleagues (2011) conducted an RCT comparing the effects of a standard expressive writing intervention and culturally adapted intervention on emotional lability and aggressive behaviors in violence-exposed, African American youth. In the standard condition, youth were instructed to write about their deepest thoughts and feelings regarding violence they had witnessed or experienced. In the culturally adapted treatment, youth were instead allowed to express themselves using rap, spoken word, poetry, songs, or skits about violence, and were encouraged to share their work with their classroom peers. The researchers assumed that such an adaptation would fit with the oral tradition of African American culture and be more engaging for Black youth. Surprisingly, the culturally adapted version was significantly *less effective* than the standard writing intervention at reducing youth aggression and mood lability at 2-months post-intervention.

Second, Webb (2009) compared the efficacy of a culturally adapted self-help smoking cessation guide for African Americans with a standard, unadapted guide. The culturally adapted guide highlighted race-based smoking statistics (e.g., 47,000 *Black* deaths per year), used religious and spiritual quotations (e.g., Bible verses), and used culturally-specific examples. In contrast, the standard guide provided general smoking statistics (e.g., 400,000 *American* deaths

per year) and made no explicit reference to race or culture. Although African American smokers reported a preference for the culturally adapted guide, the standard guide was rated as more credible. In addition, those receiving the standard guide reported greater readiness to quit smoking and more 24-hour quit attempts compared to those receiving the culturally adapted guide. When considering client specific factors, Webb (2008a) hypothesized that the culturally adapted materials would be particularly efficacious for African Americans with lower levels of acculturation, those reporting more traditional African American beliefs and values (e.g., religious/spiritual beliefs, preference for African American artists, music, or TV shows; Klonoff & Landrine, 2000). Unexpectedly, results revealed the opposite pattern – less acculturated Blacks were *less* likely to report 24-hour quite attempts when receiving the culturally-specific materials than when receiving the standard materials (Webb, 2008a). The standard, unadapted treatment proved more effective for African Americans overall, and for those who were least acculturated.

Finally, in a meta-analysis on the efficacy of smoking cessation interventions with African Americans, Webb (2008b) evaluated the effects of standard interventions and culturally-specific interventions (CSIs). CSIs used a diverse set of strategies assumed to make the interventions more culturally relevant to African Americans. These approaches included ethnic matching, using race-relevant epidemiological data, featuring materials with African Americans, delivering interventions in churches, and addressing experiences of racism among others (Webb, 2008b). The researcher found that both standard interventions and CSIs were effective; however, CSIs were more effective in the short-term (i.e., resulted in greater odds of smoking cessation at post-treatment) whereas standard interventions were more effective long-term. Webb (2008b) speculated that culturally tailored approaches may be more effective at engaging African

Americans in treatment and reducing attrition but that these benefits may decline with time, whereas standard approaches may remain more robust over longer periods.

Why might some cultural adaptations result in poorer outcomes for African Americans? Some theorists speculate that excessive or unstructured use of cultural adaptations might replace or dilute core intervention components and thus lead to inefficiencies in treatment implementation (Castro & Alarcon, 2002; Kumpfer, Alvarado, Smith, & Bellamy, 2002). Others argue that for some ethnic minority clients, the inclusion of explicit cultural adaptations may inadvertently lead to stigma or reactance (Huey et al., 2014). In the next section, we provide recommendations for tailoring treatment aimed at increasing the likelihood of improving treatment outcomes with African Americans while minimizing the likelihood of attenuating treatment effects.

Recommendations and Future Directions

Base adaptations on culturally-salient risks and strengths. One approach for enhancing mental health treatment for African Americans is to focus interventions on culturally-salient risks and strengths. Rather than develop methods that are presumed applicable across most African American clients, intervention developers can organize treatments around the specific underlying culturally relevant factors that contribute to mental health concerns of African American clients. We provide two examples of interventions that do this, with each utilizing a unique approach.

African American women are at higher risk of intimate partner violence (IPV), and those with IPV experiences are at greater risk for suicidal behavior (Kaslow et al., 1998). Recognizing this disproportionate risk, Kalsow and colleagues (2010) designed Nia (meaning "purpose" in Swahili) to reduce depression and suicidal behavior among low-income Black women with a history of abuse. The intervention targets culturally-relevant risk factors for these women (e.g.,

relationship power imbalances, unemployment) while seeking to simultaneously enhance culturally-relevant strengths. To address relationship power imbalances, Nia includes intervention didactics that directly address stereotypes of Black women's coping strategies, and teach women adaptive coping skills to improve the balance of power in their relationships. Additionally, because unemployment and financial dependence were identified as barriers to Black women ending relationships with abusers, the intervention focuses on connecting participants with affordable housing and employment opportunities. Lastly, Nia builds on culturally-relevant protective factors through its emphasis on increasing indigenous social supports (i.e., religious communities), spiritual well-being, and positive ethnic identification (Davis et al., 2009). In a randomized control trial with suicidal, African American women, Nia led to greater reductions in depressive symptoms at post-intervention and 12-month follow-up (Kaslow et al., 2010). Moreover, among those with higher levels of IPV, Nia women reported lower levels of suicidal ideation than those receiving standard care.

Multisystemic therapy (MST) is a well-established treatment for reducing criminal reoffending and conduct problems among high-risk youth (van der Stouewe et al., 2014). This community-based, family-driven intervention uses a social-ecological approach (Bronfenbrenner, 1979) for contextualizing youth problems, and targets risk factors specific to the development of youth conduct problems (e.g., deviant peer groups, school failure). MST providers intervene at multiple levels (e.g., home, school, and community) and use a diverse set of evidence-based treatments to empower caregivers and meet the individualized needs of youth and their families (Henggeler, 2011). This flexible approach allows MST to incorporate cultural strengths of African American families (e.g., extended kinship, family interdependence), which may help explain why MST is effective for African American youth, who are at greater risk of

incarceration (Brondino et al., 1996). Indeed, RCTs consistently find that African American and European American youth benefit equally from MST (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992; Henggeler, Pickrel, Brondino, & Crouch, 1996).

Nia and MST are two examples of culturally-responsive, theoretically-grounded, and empirically-validated interventions that address problems relevant to African American communities. Although both treatments address culturally-salient strengths and risks, a limitation is that none of the studies evaluating these interventions showed that targeting these factors led to improvements in treatment outcomes.

Reverse-engineer cultural competence. Another possible path to improving treatment effects with African Americans involves reverse-engineering the cultural competence construct as it relates to African Americans (Huey et al., 2014). Rather than assuming *a priori* that particular therapeutic styles or approaches are optimal for African Americans (e.g., the inclusion of Afrocentric values), one could construct cultural competence empirically by (1) dismantling existing practices and identifying components that appear to optimize outcomes for African Americans, (2) embedding such components into pre-existing interventions, and (3) evaluating whether enhanced practices improve outcomes beyond standard treatment.

There are at least three ways for investigators to pursue this initial dismantling step. First, within the context of existing practice, investigators could explore which therapeutic processes are correlated with better outcomes with African Americans. For example, Jackson-Gilfort et al. (2001) examined whether culture-related treatment processes predicted treatment engagement and symptom reduction for African Americans receiving Multidimensional Family Therapy. Participants were 18 African American youth and their families referred for substance abuse and conduct disorders. They found that in-session discussions concerning some culture-related

themes (e.g., anger/rage, journey from boyhood to manhood) were positively associated with greater alliance and engagement, whereas treatment focused on other cultural themes (e.g., trust and mistrust) were negatively associated with alliance (Jackson-Gilfort et al., 2001). Thus, this study suggests that eliciting cultural themes of a particular nature could enhance engagement for African American youth, whereas discussing other themes could be counterproductive.

A second approach involves discerning which therapeutic practices or processes are differentially impactful for African Americans compared to European Americans. For example, Sayegh, Hall-Clark et al. (*in press*) examined how patterns of treatment resistance led to differential outcomes for African American and European American juvenile drug offenders in a randomized trial of Multisystemic Therapy. They found racial differences in the trajectory of resistance during treatment, and in the predictive relationship between resistance and criminal desistance. Specifically, European Americans who desisted from crime showed a negative quadratic pattern of resistance (i.e., inverted U-shaped), characterized by low resistance at the beginning and end of treatment, yet high levels of "struggle" at mid-treatment; on the other hand, African American desisters more often showed a positive quadratic pattern of resistance (i.e., U-shaped), characterized by low levels of mid-treatment "struggle" (Sayegh et al., *in press*). One implication for therapists is that, as a forerunner to successful therapy outcomes, *low* levels of mid-treatment resistance and challenge might be expected of (or perhaps encouraged with) African American clients, whereas the opposite might be true for European Americans.

Using a different methodology for identifying therapeutic approaches that may be relatively more beneficial for African Americans, Imel and colleagues (2011) tested whether client ethnicity predicted variability in therapist efficacy in the context of a randomized trial for cannabis use. They found that some therapists were comparatively more effective at treating

White clients, whereas others were more effective at treating ethnic minority (76% African American) clients. However, given methodological limitations, they were unable to determine what specific qualities differentiated those who were competent vs. "incompetent" when treating ethnic minorities. These findings indicate that some therapists may be significantly more skilled in treating African American clients than others, although the specific qualities characterizing such therapists are unclear as yet.

A third approach would use meta-analysis to identify culturally-salient predictors or moderators of treatment success across multiple studies. Although we could find no examples specific to African American mental health problems, two meta-analyses addressed this issue with diverse samples of ethnic minority clients (Huey, 2013; Smith et al., 2011). Smith et al. (2011) assessed which elements of Bernal's cultural adaptation model[2] were associated with improved treatment outcomes in a meta-analysis of 65 controlled trials. Overall, the number of cultural adaptations (based on Bernal's model) was positively associated with treatment effects. Moreover, in terms of specific cultural elements, they found that interventions that solicited outcome goals from the client and utilized metaphors/objects from client cultures were associated with better outcomes. In an unpublished meta-analysis of culturally adapted versus non-adapted mental health treatments, Huey (2013) found a somewhat different pattern. Interventions were generally ineffective when they "explicitly" addressed ethnocultural factors, whereas interventions that were more "implicit" in nature (i.e., no apparent mention was made in treatment of the client's ethnicity/race *or* clients were unaware that treatment was culturally

[2] Bernal's eight elements of cultural adapted treatments include: (1) providing therapy in the clients' preferred language; (2) matching clients with therapists of similar ethnic/racial backgrounds; (3) utilizing metaphors/objects from client cultures; (4) including explicit mention of cultural content/values; (5) adhering to the client's conceptualization of the presenting problem; (6) soliciting outcome goals from the client; (7) modifying the methods of delivering therapy based on cultural considerations; and (8) addressing clients' contextual issues (Bernal & Saez-Santiago, 2006).

tailored) were generally more effective. The author speculated that some explicit adaptations may elicit negative responses from clients or reactance. In the context of psychotherapy, African Americans who feel that clinicians are making assumptions about them based on their race/ethnicity, may become agitated or try to belie these assumptions by behaving in ways counter to the stereotype.

However, dismantling effective approaches is only the first step in this reverse-engineering process. To our knowledge, no published studies have proceeded to the next two stages of embedding effective components into standard interventions and then evaluating the effectiveness of the presumed enhancements for African Americans.

Use "generic" strategies with implicit cultural elements. A third recommendation when treating African Americans is to utilize evidence-based strategies that are ostensibly "generic" or universal, but also implicitly culturally sensitive in that they adopt styles or address themes that might be particularly salient for African Americans. We know of at least two intervention strategies that fit this mold – role induction (Katz et al., 2004; Katz et al., 2007) and motivational interviewing (Miller & Rollnick, 2012). Although sometimes used as stand-alone interventions, more often these serve as brief, add-on strategies to conventional therapies.

Role induction is a brief, engagement technique that involves clarifying client and therapist roles, identifying and correcting misperceptions about treatment, and problem-solving barriers to treatment (Katz et al., 2004; Walitzer, Dermen, & Connors, 1999). Because African Americans perceive more stigma with regard seeking treatment and are less trusting of mental health professionals (Whaley, 2001), some experts recommend role induction as an engagement strategy for African Americans that strengthens the therapeutic relationship by clarifying the treatment process. In fact, several published studies strongly argue for the effectiveness of role

induction with this population. Katz et al. (2004) randomly assigned treatment-seeking drug abusers (98% African American) to receive either a brief role induction session or standard group orientation. Those receiving role induction were significantly more likely to attend an initial counseling session and remain in treatment, and marginally more likely to abstain from drugs during treatment. In a subsequent trial, African American (96%) drug abusers were randomly assigned to individual role induction or standard orientation (Katz et al., 2007). Compared to controls, role induction participants were significantly more likely to attend at least one post-orientation session, and showed significantly larger reductions in substance use at 6-month follow-up. Thus, brief role induction appears to be a promising approach to engaging and treating African Americans.

Motivational interviewing (MI) is another evidence-based, conventional treatment with potential relevance for African Americans. MI is a brief counseling approach that promotes behavior change by resolving client ambivalence; it utilizes empathy building, "rolling with resistance," and elicitation of change talk, among other strategies (Miller & Rollnick, 2002). Given its approach to client resistance, MI may be a natural fit for African Americans and other populations that experience disparities in treatment seeking and engagement (Interian, Martinez, Rios, Krejci, & Guarnaccia, 2010; Miller et al., 2008). MI encourages clinicians to work within the patient's values, and this might be conducive to cultural humility (a therapeutic stance characterized by respect for and a lack of superiority towards the client's cultural background or experiences; Hook, Davis, Owen, Worthington, & Utsey, 2013) and understanding by clinicians. Indeed, multiple MI trials with predominantly African American samples demonstrate its effectiveness in terms of treatment engagement (e.g., Longshore, Grills, & Annon, 1999; Montgomery, Burlew, Kosinski, Forcehimes, 2011) and reducing drug use problems (e.g.,

Bernstein et al., 2005; Longshore & Grills, 2000; Stotts, Schmitz, Rhoades, & Grabowski, 2001). Moreover, a meta-analysis by Hettema, Steele, and Miller (2005) indicates that MI may actually be more effective with ethnic minority samples than with European American samples.

Although "culture-neutral" at face and universal in practice, these two strategies include design features that implicitly increase their potential relevance for African Americans. Thus, some standard approaches that subtly address culturally-salient risk or relationship factors might be particularly effective with African Americans, without requiring specialized adaptation or tailoring.

Conclusion

In the preceding sections, we have highlighted clinical issues pertinent to African Americans, summarized treatment outcomes with African Americans, outlined approaches to cultural competence and cultural tailoring, evaluated empirical support for culturally adapted treatments, and made recommendations for those interested in improving the quality of treatment for African Americans. Clear and persistent disparities in treatment utilization, access to care, and treatment quality suggest that a focus on improving mental health services for African Americans is warranted. At the same time, treatment outcome research shows that psychotherapy is generally effective with African American youth and adults and that, on average, treatment is as beneficial for African Americans as it is for other ethnic groups, including European Americans. With respect to culturally tailored interventions, the available evidence indicates that they are effective with African Americans, but few studies utilize designs that allow us to isolate specific types of cultural tailoring that improve outcomes for African Americans, or to determine whether culturally tailored interventions yield outcomes that are superior to unadapated EBTs. Research demonstrating the enhanced efficacy of adapted treatments compared with other

treatment approaches is promising, but few methodologically rigorous studies have focused specifically on African Americans. Importantly, we question whether all forms of cultural tailoring are uniformly beneficial for African Americans, and provide examples of cultural tailoring that yielded poorer outcomes compared with standard unadapted interventions. To reduce disparities and improve treatment outcomes with African Americans, we suggest that researchers continue to rigorously evaluate culturally adapted interventions, with emphasis on whether specific cultural tailoring improves treatment utilization and engagement, the area where disparities are most consistently observed.

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Table 1.

Examples of EBTs for African Americans with Behavioral Health Problems

Target Problem	Age Group	Representative EBTs
ADHD	Youth	Behavioral treatment + stimulant medication (Arnold et al., 2003)
Anxiety-Related Problems	Youth	Group CBT (Ginsburg & Drake, 2002)
	Adult	Panic Control Therapy (Carter et al., 2003)
Antisocial Behavior	Youth	MST (Borduin et al., 1995)
Depression	Youth	Attachment-based family therapy (Diamond et al., 2002)
	Adults	Collaborative care for depression (Areán et al. 2005)
Schizophrenia	Adults	Assertive Community Treatment (Kenny et al., 2004)
Smoking	Adults	CBT plus Nicotine replacement therapy (Murray et al., 2001)
		Group CBT (Webb et al., 2010)
Substance Use Problems	Youth	Multidimensional Family Therapy (Liddle et al., 2008)
	Adults	Contingency management (Milby et al., 1996)
Suicidal Behavior	Youth	MST (Huey et al., 2004)
	Adults	Nia Empowerment Intervention (Kaslow et al., 2010)
Trauma-Related Problems	Youth	Prolonged exposure (Foa et al., 2013)
	Adults	Prolonged exposure (Feske, 2008)

Mixed/Comorbid Problems	Youth	RECAP Intervention (Weiss et al., 2003)
	Adults	Seeking Safety (Boden et al., 2011)

Note: ADHD = Attention-Deficit/Hyperactivity Disorder; CBT = Cognitive-Behavioral Therapy; EBT = Evidence-Based Treatment; MST = Multisystemic Therapy; RECAP = Reaching Educators, Children, and Parents.