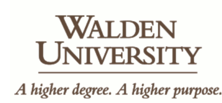

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Walden University

College of Social and Behavioral Sciences

This is to certify that the doctoral dissertation by

LaRae Ferman-Tillis

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University

2016

Abstract

The Impact of African-Centered Psychotherapy on Depressive Symptoms and Africentric

Worldview in African Americans

by

LaRae Ferman-Tillis

MA, University of Akron, 2002

BA, University of Akron, 1999

Dissertation sSbmitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

General Psychology

Walden University

October 2016

Abstract

Depression is a prominent issue in the African American community. However, there are significant gaps in the literature on the delivery and outcomes of culturally relevant mental health psychotherapy to African Americans. Cultural variables, such as worldview, have been noted to impact an individual's overall psychosocial functioning and have significant implications for mental health service delivery. The purpose of this study was to use archival data to analyze the impact of African-centered therapeutic services on depressive symptoms and on Africentric worldview among African Americans. Archival data on 38 African American adults, recorded from 2012-2015, were obtained from a community mental health agency in the Midwest. Each of the adults received therapy via an African-centered treatment modality. The study was grounded in the cognitive theory of depression and optimal theory. The dependent treatment outcome variables were (a) depressive symptomology, as measured with the depression subscale of the Symptom Checklist-90-Revised and (b) Africentric worldview as measured by the Belief Systems Analysis Scale. The dependent variables were measured twice: once in the beginning and once at the end of a year's treatment. A dependent, paired *t* tests indicated a significant reduction in depressive symptoms but no significant increase in adherence to Africentric worldview. This study has implications for positive social change by: providing increased insight on the need for culturally relevant services to African Americans, which can subsequently lead to culturally relevant social change in the delivery of mental health services to diverse populations.

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September 2016

Dedication

This research is dedicated to my ancestors that fought for our people to have equal rights and to be acknowledged for our accomplishments and contributions. This research is also dedicated to my parents as I know that I have made you proud in working hard to achieve a goal I set forth to accomplish. To my husband and my rock: I would have not been able to achieve this without your love, support, and encouragement. Please know that I recognized every moment that you supported me and allowed me an opportunity to accomplish what I needed to. I could not have done this without your love and support I thank God for you every day. To my sons: I did this for you because we are going to build a legacy that our ancestors were not able to. My love for you is so profound that words cannot express the depth. Know that I love you and nothing can stop you from achieving your goals. To my brother, sisters, nieces, nephews, and extended family: let this be a testament to our ability to accomplish anything we set forth to achieve. I am because we are, so continue to strive for excellence regardless of any barriers placed in your path.

Acknowledgements

I would like to thank my chair, Dr. Tony Wu for his assistance in completing my dissertation. I would also like to thank my co-chair, Dr. Magy Martin for your inspiring words. Thank you to Dr. Donna Heretick for your valuable insight and input. Finally, I would like to thank all of the individuals that provided mentorship, support, and encouragement during my research process.

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Chapter 1: Introduction to the Study

Introduction

Cultural competence and culturally relevant treatment approaches are forefront issues in psychology. This study filled a gap in the research on treatment outcomes when receiving treatment from a culturally specific approach. Culturally competent treatment emphasizes the professional's level of awareness of how culture impacts mental health and psychotherapy (Sue, 2006). This study was expected to contribute to positive social change as the results can help increase knowledge on the impact that delivering culturally relevant therapeutic services can have in reducing depressive symptoms and increasing Africentric worldview.

This quantitative study explored the relationship between depressive symptoms and African-centered therapy. It also explored the relationship between African-centered therapy and Africentric worldview. The current research on Africentric worldview and African-centered therapy is limited. Sue (2006) emphasized the need for culture-specific expertise in working with particular groups or populations. Increasing knowledge into a culturally relevant psychotherapeutic approach, and outcome information on a culturally-specific treatment approach could lead to more research in this area as well as to increased treatment provisions in order to meet the diverse cultural needs of African Americans.

This chapter provides background information on this topic; identifies the purpose of this study and the research questions; details information regarding the theoretical framework used in the study; give information on the nature of this study; defines key terms; discusses study’s potential contributions.

Background

Cultural competence assumes that providers possess the necessary knowledge and skills to work with individuals of various cultural backgrounds (Sue, 2006). Worldview is an important aspect of cultural competence as it shapes an individual's functioning and belief system. Cultural differences in worldview lead to differences in how an individual assess her or his circumstances; services should be personalized to the client's internalized worldview (Walker, Alabi, Roberts, & Obasi, 2010).

Worldview can be defined as the structure of principles, assumptions, and values that guide an individual's perceptions and behaviors. Worldview can vary among cultural groups and because of its relationship to an individual's emotional state and feelings of well-being; it can significantly impact psychosocial functioning (Neblett, Hammond, Seaton, & Townsend, 2010). *Africentric worldview* is defined as a set of beliefs, values, and assumptions that reflect basic African values; it is found among persons of African descent (Belgrave, Townsend, Cherry, & Cunningham, 1997). The Africentric worldview includes the following dimensions: spirituality (belief in a being that is greater than an individual); collectivism (describing an emphasis on cooperation amongst others); time orientation (equal recognition to the past, present, and future); orality (preference of oral communication); sensitivity to affect and emotional cues (being in tune and sensitive to the feelings and emotional needs of others); verve and rhythm (rhythmic and creative behavior); and balance and harmony with nature (balance of one's mental, physical, and spiritual state (Belgrave & Allison, 2006).

Based on an Africentric worldview, African-centered therapy is a holistic approach that examines the client's belief system and worldview and works to help

increase self-knowledge and intrinsic self-worth (Queener & Martin, 2001). This treatment approach is used to help improve psychological adjustment issues such as depression and perceived distress. This study filled a gap in knowledge on African-centered therapy and the need to explore culturally- specific treatment modalities in African Americans.

Problem Statement

The need for culturally relevant mental health services is pertinent due to the significant role that cultural awareness has in treatment effectiveness (Sue, 2006). Few studies have explored mental health issues among African-Americans. Most depression treatment studies include primarily European American middle-class populations (U.S. Department of Health and Human Services, 2001) and little is known about the usefulness of established treatments for more disadvantaged populations such as African Americans (Siddique, Brown, Chung, & Miranda, 2012).

Inadequate data on African Americans contributes to problems of misdiagnosis, under-diagnoses, and under treatment of depression among African Americans (Carrington, 2006). Further research involving African Americans is needed to identify viable treatments to prevent and reduce health disparities (Betancourt, 2006). This study explored treatment outcomes of African-centered therapy and the impact of such services on depressive symptoms and on the Africentric worldview in African American adults.

Purpose of the Study

The purpose of this quantitative study was to use a paired *t* test to examine the effect that a specific African-centered therapy has on depressive symptoms and African-centered worldview. This research sought to increase knowledge about (a) the treatment

outcomes of African-centered therapy and (b) knowledge in the delivery of culturally relevant services.

Variables

The independent variable in this quantitative study was African-centered therapy. The specific approach reviewed was Belief Systems Analysis (BSA). The dependent variables in this study were depressive symptoms and an Africentric worldview.

Research Questions and Hypotheses

Research Question 1: Will depressive symptoms decrease as a function of receiving African-centered therapy among African American adults?

*H*1A*:* Depressive symptoms will decrease after receiving African-centered therapy among African American adults.

*H*10*:* Depressive symptoms will not decrease after receiving African-centered therapy among African American adults.

Research Question 2: Will adherence to an Africentric worldview be affected after receiving African-centered therapy among African American adults?

*H*2A*:* Adherence to an Africentric worldview will increase after receiving African-centered therapy among African American adults.

*H*20*:* Adherence to an Africentric worldview will not increase after receiving African-centered therapy among African American adults.

This study consisted of 38 adult men and women that ranged between the ages of 19-65.

Theoretical Foundation

This study integrated Beck's (1979) cognitive theory of depression and optimal theory. According to Dr. Aaron Beck's theory, depression is maintained by negative thought processes and maladjusted beliefs (Beck, 1979). This theory has been a frame of reference in a significant amount of research and treatment of depression (Allen, 2004). Cognitive theory is related to this study as it provides a conceptualized framework for depression and depression treatment; more specifically, is related to the framework for optimal theory and BSA which works to reframe an individual's thinking and how they view their experiences.

Beck's cognitive theory of depression contributed to the development of cognitive behavioral therapy (CBT). This traditional treatment approach is used to help patients recognize the relationship between their thoughts, feelings, and behaviors and guide them through structured learning experiences (Butler & Beck, 1995). This approach helps patients work on ways to overcome issues related to distorted beliefs and thoughts, to learn more realistic ways to formulate their experiences, and to help them modify their emotional and behavioral responses.

Developed by Myers (1988), optimal theory is another theoretical framework that was used for this study. This theory is relevant to this research in that a sub-optimal Africentric worldview has been related to depression and this study sought to acquire increased insight on how Africentric worldview and depression are interconnected. Africentric worldview can serve as a buffer between stress and psychological dysfunction and low Africentric worldview scores has been correlated with increased depressive symptoms (Neblett et al., 2010).

Nature of the Study

This quantitative study examined the relationship amongst African-centered therapy, depressive symptoms, and Africentric worldview. Archival data from 2012-2015 was used; the source was an agency that provides mental health services using an African-centered approach. The data was used to provide information on depressive symptoms and adherence to Africentric worldview among participants,

Two quantitative measurement tools were used: the Symptom Checklist-90-R (SCL-90-R) and the Belief Systems Analysis Scale (BSAS) (Montgomery, Fine & Myers, 1990). The BSAS measures adherence to Africentric worldview. The participants completed the checklist and scale twice: before -treatment and after one-year of treatment. A paired *t* test was used to determine if depressive symptoms and Africentric worldview changed after receiving therapeutic services based on BSA.

Definitions

African-centered therapy: African-centered therapy is a holistic treatment approach that works to positively influence psychological adjustment issues by examining the client's belief system and worldview (Neblett et al., 2010; Queener & Martin, 2001).

Africentric Worldview: Africentric worldview describes a set of beliefs, values, and assumptions based on African values (Belgrave et al., 1997).

Depression: Depression is defined as a depressed mood most of the day, every day; diminished interest or pleasure; insomnia or hypersomnia; fatigue; feelings of worthlessness; diminished ability to think or concentrate; or recurrent thoughts of death (American Psychiatric Association, 2013).

Oppression: Oppression is defined as imposing labels, roles, experiences, or living conditions that are unwanted, painful, and negatively influence the well-being of others (Hanna, Talley, & Guidon, 2000).

Worldview: Worldview is the structure of principles, assumptions, and values that guide and individual's perceptions and behaviors (Neblett et al., 2010).

Assumptions

In this study, it was assumed that (a) participants were receptive to receiving therapeutic services that were African-centered; (b) participants were able to comprehend the questions on the SCL-90-R and the BSAS and did not underreport or over report their symptoms; and (c) the therapists had a comprehensive understanding of Africentric worldview and the provision of African- centered therapy based on when they began employment. The master's and doctoral-level therapists who provided treatment were employed at a mental health agency with an African-centered treatment modality (BSA). All had received training and ongoing supervision on this treatment modality; all had been taught how to engage clients using this approach.

Scope and Delimitations

This study concentrated on the impact of Africentric treatment on depression and worldview; no other mental health concerns of the African American community were addressed. Based on available archival data, this study was limited to (a) a geographical section of the United States and (b) 38 adults who received services from one mental health agency with a specific treatment modality. The generalizability of the results could be impacted as the data was gathered from a small sample at a single mental health agency.

Limitations

The limitations discussed below are related to internal and external validity.

Issues of Internal Validity

In this study, issues with internal validity included (a) attrition and client receptiveness to treatment interventions and recommendations, (b) the variety of clients' personal experiences during the course of treatment (significant life changes, medication treatment, and client/therapist rapport) that may have influenced their symptoms and worldview. .

Limitations with Regard to External Validity

This study sought data that was representative of African American demographics. However, the limited number of participants presented some external limitations. Another limitation was the presence of the client's therapist during the participants' annual case update: the presence of the therapist may have impacted the client's response on the instruments.

Significance of the Study

According to estimates, half of the United States population will be comprised of ethnic and racially diverse individuals by the year 2052 (Carrington, 2006). The assumption that the current popular treatment modalities for depression are universal and relevant to all races may be invalid as mental health studies based on European Americans may not sufficiently address mental health issues among African Americans (Sohail, Richie, & Kennedy Bailey, 2014; United States Department of Health and Human Services, 2005). This study captured data from an African American participant pool. Diagnostic and treatment studies on depression among African Americans have

been lacking for decades (Carrington, 2006; Das, Olfson, McCurtis, & Weissman, 2006). With respect to mental health, African Americans have traditionally been underserved, understudied, and misdiagnosed (Sohail et al., 2014).

Morris (2001) posits that not all African Americans come from the same cultural mindset, have the same worldviews, and are at the same stage of identity development. African Americans have similar cultural roots and have experienced, to varying degrees, the effects of racism and the divergent impact of Eurocentric thinking in their psychosocial development. This study provided insight into the impact and outcomes of receiving culturally relevant mental health treatment services has on the overall functioning of African Americans. Morris (2001) stated that cultural factors, barriers to service, and financial restrictions may be issues that lead African Americans to underuse mental health services. However, these limitations presented limited insight into the history and experiences of African Americans and how such experiences impact their psychological processes. This research sought insight into some of the broader issues that have damaged the psychosocial functioning of African Americans and to determine the impact of a culturally relevant treatment approach.

Summary

This chapter presented information on the relevance of culturally competent mental health treatment provision for African Americans. This chapter also provided information on how worldview impacts psychosocial functioning, particularly for African American clients. Education and training in cultural competence may enhance provider skills and improve treatment outcomes when working with diverse individuals (Delphin & Rowe, 2008). This chapter also defined Africentric worldview and African-centered therapy as it relates to the provision of culturally-relevant treatment services.

The purpose of the quantitative study contributed to filling a gap in research and knowledge on culturally relevant treatment approaches. A culturally and linguistically competent workforce can help address barriers and disparities by expanding knowledge about effective ways to treat and engage diverse populations (Matter, 2011). Using archival data, a paired samples *t* test was used to measure the difference in means between the SCL-90-R depressive subscale scores and the BSAS scores which measured Africentric worldview.

In Chapter 2, a review of literature will include information on depression, Africentric worldview, traditional depression treatment approaches, and African-centered treatment approaches. In Chapter 3, information on the research design for this quantitative study, methodology, threats to validity and reliabilities, and ethical procedures will be provided. Chapter 4 provides information on the paired *t* test results and Chapter 5 provides information on the interpretation of findings, study limitations, and implications of the study.

Chapter 2: Literature Review

Introduction

This research examined treatment outcomes of African Americans receiving culturally relevant mental health services. With the prevalence of depression in the African American community, the delivery of culturally relevant therapeutic services continues to be a significant issue in mental health service delivery (Matter, 2011). Although there is research on cultural treatment mental health provisions for African Americans and other minority groups, it is limited and outdated regarding the impact and outcomes of African-centered therapy on the mental health functioning of African Americans. In an effort to understand and address health disparities and to promote research with a wider range of populations, federal agencies have required that ethnic minorities be represented in all clinical research, but researchers have been apprehensive about their ability to recruit minorities (Corbie-Smith, Thomas, & St. George, 2002). This study provides current outcome information on how receiving services from an Africentric approach impacts clients' depressive symptoms and Africentric worldview.

The prevalence of depression among African Americans is twice that of European American and depression in African Americans persists longer, thus making depression a chronic disorder among African Americans (Sohail et al., 2014). African Americans comprise 14.2% of the population in the United States and it is estimated that by 2060, African Americans will represent 18.4% of the population (Center for Disease Control, 2012). African Americans represent a growing population. The Center for Disease Control (2010) also reports that African Americans have a 4% increased likelihood of

reporting depressive symptoms, only 7.6% seek treatment compared to 13.6% of the general population.

The delivery of culturally competent therapeutic services continues to be a significant issue in mental health service delivery. As evidenced by the literature review, there is research on depression treatment provisions for African Americans but research on the impact and outcomes that receiving African-centered therapy has on the mental health functioning of African Americans is limited.

This chapter covers a review cognitive theory and optimal theory as it relates to the specific variables to be explored in this research. This chapter also reviews studies regarding depression in African Americans; traditional forms of depression treatments; oppression and the relationship to depression in African Americans; Africentric worldview; and a background on African-centered treatment approaches. The chapter concludes with a summary of BSA as it relates to determining the impact of culturally relevant treatment provisions in African Americans.

Literature Search Strategy

The following databases were used: PsycINFO, PsycARTICLES, Google Scholar, and Academic Search Complete. While every effort was made to obtain peer-reviewed literature published within the last 10 years, this researcher encountered limitations in research on the provision of culturally relevant treatment for depression. Literature beyond the 10-year limit was kept because it presented valuable foundations for this study. The following keywords were used: *cultural competence, depression, depression, African Americans, culturally relevant therapy, worldview, Africentric worldview oppression, treatment,* and *African-centered therapy*.

Cognitive Theory

Beck developed the cognitive theory of depression which stated that depression is sustained by adverse biases in how one processes information and dysfunctional beliefs (Butler & Beck, 1995). According to this theory of depression, negative thoughts developed when experiencing distress lead to the development of cognitive distortions, negative cognitive triad, and subsequent depression. Cognitive distortions cause negative experiences to be interpreted with restricted ability to consider rational explanations for the same event (Beck, 1975). In a therapeutic application if this theory, the client is guided to recognize the relationship between their thoughts, feelings, and behaviors through structured learning experiences (Butler & Beck, 1995). This theory provides an empirical framework for understanding depression the development of depression treatments.

Optimal Theory

Mental illness is caused by the imbalance in various components of the individual self and an increase in self-knowledge can lead to self-acceptance, self-help, discovery, and preservation (Akbar, 1995; Queener & Martin, 2001). Based on Africentric psychology and providing the theoretical framework for BSA, optimal theory was developed by Linda James Myers in the 1980s. Optimal theory suggests that self-knowledge is the basis of all knowledge, wisdom, and insight into oneself will lead to increased health (Myers, 1988). According to this theory, the “normal” worldview in this society is based on a suboptimal conceptual system that creates a state of consciousness that is self-alienating, self-destructive, un-healthy, and depriving (Myers et. al., 1991). The traditional or “normal” worldview is not aligned with an Africentric worldview. In

attempting to assimilate into the dominant culture, many African Americans have internalized a Eurocentric worldview and reject beliefs about their culture (Jackson & Sears, 1992).

Optimal theory is built on the framework for identifying and getting beyond the conceptual implications from a Eurocentric worldview and provides a framework for establishing and maintaining an optimal worldview (Myers & Speight, 2010). This theory emphasizes the process of moving from a suboptimal worldview to an optimal view of the world by bringing one's thoughts, feelings, and biases regarding oneself and others into conscious awareness (Speight, Myers, Cox, & Highlen, 1991). The core of optimal theory is spirituality in that all human beings are spirit and therefore all life is interconnected and should be valued. Optimal theory emphasizes the connectedness of one's spiritual, mental, physical, social, and environmental functioning (Myers & Speight, 2010).

In the suboptimal conceptual system, spirit and matter are fragmented and segmented which results in individuals being estranged from their spiritual essence (Myers et al., 1991). There is an emphasis on self-knowledge and intrinsic self-worth with the idea of assisting individuals from endorsing a disjointed view to understanding a more holistic view of self. When an individual does not understand their intrinsic self-worth, they tend to rely on external validation for feelings of self-worth, resulting in factors such as skin color, social class, academic level, and occupation becoming critical in defining their identity (Speight et al., 1991).

Devoted to gaining insight into an individual's level of consciousness, this theory provides awareness into the sacred spirituality of every individual and what it means to

be connected to the Supreme Being (Myers & Speight, 2010). Optimal theory posits that an Africentric worldview is optimal and that an individual can transform from a fragmented suboptimal worldview to an optimal conceptual system and worldview.

Depression and African Americans

Major depressive disorder is one of the most common and costly mental disorders (Slavich & Irwin, 2014). Worldwide, major depression disorder is the second leading cause of disability according to the global burden of disease study (Ferrari et al., 2013). Individuals with major depressive disorder experience a severely depressed mood that lasts for two weeks or more and presents with symptoms that cause clinically significant distress or impairment in social, occupational, or other important areas of functioning (American Psychiatric Association, 2013).

According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.), symptoms can include depressed mood most of the day, every day; diminished interest or pleasure; insomnia or hypersomnia; fatigue; feelings of worthlessness; diminished ability to think or concentrate; or recurrent thoughts of death (American Psychiatric Association, 2013). Depression in African Americans can be expressed through non-traditional symptoms such as hypertension; dizziness or feeling that one may suddenly collapse or "fall out," or by sleep paralyses (Sohail et al., 2014). Depression is often treated with psychotherapy, psychiatric medication, or a combination of both approaches. In providing treatment to an individual who has been identified as depressed, it is important that an individualized treatment approach is used as a way to ensure that their mental health needs are met.

Ethnic minorities, women, persons with educational or employment limitations, and individuals without health insurance have an increased likelihood of meeting the diagnostic criteria for major depression but have a reduced likelihood of seeking or receiving mental health treatment (Siddique et al., 2012; Depression Statistics, n.d.). African Americans are less likely to seek treatment for depressive symptoms. Williams et al. (2007) used findings collected in the National Survey on American Life to further explore correlates of mental disorders and found that although depression is more debilitating for African Americans, only one in two reported to receive treatment. African Americans are approximately 50% less likely than whites to consider treatment for depression, and when African Americans are engaged in treatment, there is an increased risk for premature termination rates (Constantine, Redington, & Graham, 2009).

Treatment retention is a relevant concern to consider in treatment delivery in African American population. Breland-Noble, Bell and Burriss (2011) conducted a qualitative study using twenty-four African American adolescents diagnosed with depression to explore methods of enlisting and retaining African American youth in mental health treatment. Their research indicated that a significant barrier in treatment retention is stigma associated with mental health treatment. The results also indicated that clinicians should have an awareness of the need to openly discuss issues surrounding culturally embedded mistrust of the medical community and understand how to work with their client's to reduce the barriers of negative culturally entrenched definitions of depression are beneficial in engaging African Americans in treatment and studies about treatment outcomes (Breland-Noble, Bell, & Burriss, 2011).

African Americans are concerned with the stigmatization of mental illness and feel it is important to distance oneself from a stigmatized group (Breland-Noble, Bell, & Burriss, 2011). Chandra et al. (2009) conducted a research study to explore how parental views impact teens' perspectives on depression treatment. They found that negative parental perceptions had reduced the teens' willingness to comply with treatment recommendations. The authors also found that African American parents are significantly concerned about potential mislabeling of their children and a lack of the provision of appropriate treatments to their children (Chandra et al., 2009). Consequently, negative perceptions about mental illness have been documented to be a significant barrier to help-seeking behavior for African Americans. African Americans often engage in alternative forms for mental health care such as the church and faith community (Breland-Noble, Bell, & Burriss, 2011).

Ward, Wiltshire, Detry, and Brown (2013) conducted a study to explore African American beliefs about mental illness, their view regarding seeking mental health services, coping behaviors, and the differentiation of those variables according to gender and age. The authors utilized a cross-sectional survey design using 272 participants aged 22-72 living in a community dwelling. The measurements used in the study include: Brief Symptoms Inventory which is a mental health screening tool used to assess and identify and psychopathology; the Inventory of Attitude Toward Seeking Mental Health Services which assesses an individual's attitude in considering mental health treatment; and the Preferred Coping Scale to assess preferred coping in African Americans are the measurement tools used in the study. The study found that older African Americans have a tendency to view depression as a lack of inner strength and as a weakness. Among men

and women participants, there was a common perception that mental health concerns can be resolved without professional intervention, and gender/age did not have a role in views of stigma (Ward, Wiltshire, Detry, and Brown, 2013). The study also found that although women were slightly more willing to seek services, there were high rates for religious coping for both men and women.

The mistrust toward public health and/or mental health treatment entities among African American communities has been deeply rooted for many historical reasons (Brown & Moyer, 2010). The Tuskegee Experiment is an example of how African Americans were exploited. This study was facilitated by the United States Public Health Service and negatively impacted how African Americans perceive research studies, the quality of clinical care, and overall view of service providers (Breland-Noble, Bell, & Burriss, 2011). The Tuskegee experiment began in 1932 and consisted of a total of 600 African American male participants. Of those participants, 399 of the men were diagnosed as having Syphilis and 201 participants did not have a syphilis diagnosis. Study participants in the study were not informed about the real intent of the study and actively engaged this research project as a way to be treated for what they thought was "bad blood." The Tuskegee experiment was initiated to have 6-month duration but persisted for 40 years. In exchange for their participation, the men were provided with meals, medical exams, and burial insurance but the participants that were infected with syphilis were not treated properly to alleviate the disease (Tuskegee experiment, 2013).

As a result of this experiment, African Americans might be resistant to engage in studies and treatment due to the unknown intentions of non-African American researchers, fear of being exploited, and uncertainty about the research process (Brown &

Moyer, 2010). African Americans could also be hesitant in disclosing personal information in the fear of exploitation and this cultural mistrust may represent a significant obstruction to effective treatment. The authors assert that African Americans' adverse view of study participation may result from perceptions of racial and cultural mistrust (Constantine et al., 2009).

African Americans' mistrust of healthcare is based on the historical mistreatment of African Americans by the medical establishment combined with personal experiences of racism and discrimination in and out of healthcare (Mosley et al., 2007). Trust can influence patient outcomes and treatment compliance. Some African American clients could assume that White counselors are racially biased and will offer input that is not in-line with their cultural values which may lead to the perception of counseling as an instrument of oppression (Sue & Sue, 2003).

Townes, Chavez-Korell, and Cunningham (2009) piloted a study to explore the degree that African American racial attitudes, help-seeking attitudes, and racial attitude have on predicting their preference for an African American counselor. The sample consisted of 128 African American adults from college (71 women and 57 men) and 76 African American adults who were not enrolled in college (39 women and 37 men). The participants completed the Cross Racial Identity Scale, the Attitudes Toward Seeking Professional Psychological Help-Short Form, the Cultural Mistrust Inventory, and a variation of the Counselor Preference Scale. The study found that mistrust, negative view of racial assimilation, and elevated Africentric views had a significant impact on an individual's preference of having an African American counselor (Townes et al., 2009).

The concept of African Americans developing distrust as a result of historical and ongoing experiences with oppression and racism was introduced by Grier & Cobbs (1968). The authors sought to illustrate aspects of African American psychotherapy and psychosocial functioning that is directly attributed to the African American experience with racism, inferior treatment, and systemic oppression. By providing a series of case illustrations on individual African Americans are challenged by racism and oppression in daily facets of life such as employment, housing, and in educational settings. The authors brought forth a comprehensive understanding as to why some African Americans have difficulty trusting White Americans and the psychological impact of that mistrust. The mistrust of white counselors has led to African American clients' lack of treatment engagement, decreased treatment expectations, and misdiagnosis (Austin, Carter, & Vaux, 1990).

The ongoing growth of ethnically diverse cultural groups brings forth the necessity for more culturally relevant treatment modalities. Eurocentric views may not be applicable in service delivery of mental health treatment for African Americans and other racially diverse groups. Cultural competence entails having knowledge about how historical, political, and social events impact the overall health of culturally diverse groups (Developing Cultural Competence in Disaster Mental Health Programs, 2003). Recognizing the significance of delivering culturally competent services in the field of psychology, the American Psychological Association (APA) established Guidelines on Multicultural Education, Training, Research, Practice, and Organizational Change for Psychologists to help increase awareness and how culture impacts psychological

functioning. Early detection and culturally sensitive approaches for depression can help mitigate the adverse effects of depression (Bryant-Bedell & Waite, 2010).

Inadequate and insufficient research has a significant role in concerns regarding systemic issues with misdiagnosis and the underutilization of treatment of African Americans (Carrington, 2006). Cultural bias may reflect a misinterpretation of cultural behaviors as psychopathology (Whaley, 2011). As such, research yields an unclear picture of the prevalence of risks and symptom severity associated with depression in African Americans. A challenge in quantifying and understanding depressive symptoms among the African American population is that African Americans endorse more somatic symptoms than cognitive (Walker & Hunter, 2009).

Learning the cultural indicators for depression, anxiety, attachment, and loss in African Americans may serve as a guideline for a more comprehensive understanding of symptom presentation and lead to appropriate diagnoses of potential mental health issues. Diagnoses that are used excessively including attention disorders, schizophrenia, personality disorders, and oppositional-defiant conduct in African Americans can be reconsidered with the knowledge of cultural differences in how symptoms are presented and manifested (Toldson & Toldson, 2001).

Psychiatric diagnosis entails the capacity to distinct cultural behaviors from psychopathological behaviors (Whaley, 2011). There are social and cultural differences in how depression is expressed by different ethnic groups. Understanding the cultural norms and folkways of expression can help gain a better understanding of presenting symptoms in individuals from diverse cultures (Carrington, 2006). Culture influences how depressive symptoms are experienced and communicated and providers should have

a level of understanding about cultural distinctions of depressive terminology and the expression of depressive symptoms (Bryant-Bedell & Waite, 2010).

An emphasis on cultural differences may assist researchers and clinicians in understanding the experience of depression in African Americans (Black et al., 2011). The authors conducted a qualitative study of 60 elderly African Americans with varying levels of health and function to explore their perception of depression. The participants in the study often expressed depression through metaphors to express a variety of emotions, processes, and physical manifestations (Black et al., 2011). The study found that the idea of depression is often rejected; cultural, ethnic, and religious terms were used to describe symptoms of depression; there was a strong belief that an individual has a power of choice and control over depression as blocking depressive thoughts would eventually resolve those thoughts; and depression is attributed to experiencing "difficulties" as opposed to a mood disorder that needs treatment (Black et al., 2011).

Bryant, Bedell, and Waite (2010) conducted a study to explore depression in middle-aged African American men to explore how they recognized and expressed depressive symptoms and how such symptoms impact their lives. The results of the qualitative study found that the men do not want to deal with the stigma of depression, felt embarrassed about being depressed, and felt that it is more comfortable to be isolated from others than to mask that all was well with them. The study also found that feelings of frustration were experienced as the men felt that they should be able to improve their mood because they felt that they have the capacity to control their thoughts. The study participants reported manifestations of depression such as headaches, fatigue, poor hygiene, and poor eating habits. Spirituality was a fundamental coping skill used by the

study participants and described as critical to their belief system which acted as a restraint from acts of suicide (Bryant et al., 2010). The significance and intimacy of one's relationship with God, their ancestors, and their community cannot be underrated in addressing issues of depression in African Americans (Black et al., 2011).

In a qualitative study conducted by Waite and Killian (2008), the authors sought to explore health beliefs of African American women as it relates to depression. The authors posited that examining the beliefs regarding depression will provide insight into African American women's (AAW) expression of depressive symptoms and their willingness to seek treatment. Descriptive data was collected from three focus groups which allowed exploration of feelings, group norms, opinions, and cultural values. The sample consisted of 14 AAW ranging between 18-64 years of age that had been diagnosed with depression within the past year. Participants engaged in semi-structured interviews, completed a socio-demographic questionnaire, and was administered the patient health questionnaire to assess depression severity and to monitor treatment response.

The results of the study found that many participants identified depression as being a "mind thing" that can be managed and that depression was not serious until there were significant changes in their ability to engage in daily tasks and in their overall mental functioning. The study also found that treatment barriers included distrust of the medical provider, denial that they were depressed, stigma, and lack of knowledge about how depression manifests (Waite & Killiam, 2008).

The focus groups provided insight into AAW's perceptions of vulnerability and social barriers related to depression treatment such as stigma, religious beliefs, images of

being strong, and distrust of the medical profession (Waite & Killian, 2008). The authors discuss the importance of medical providers building a strong rapport with their African American patients and understand their expression of depressive symptoms. Some African Americans reason that if an individual is poor or a person of color, they are considered to be a guinea pig for medicine as an African American life is not as valued as a White life in America (Waite & Killian, 2008).

Oppression and Depression

Understanding psychological issues in African Americans also means having an understanding of who African American people are and how adaptive and maladaptive coping skills are used while functioning in a Eurocentric society (Walker & Hunter, 2009). The African American experience with oppression and the impact that such experiences may have on their psychological functioning should be considered in treatment provision. Depressive symptoms in African Americans can be associated with their experiences with oppression, racism, and ongoing marginalization (Black, Gitlin, & Burke, 2011).

The current climate of the United States provides insight on the ongoing racial experiences of African Americans. In 2014 and 2015, grand jury decisions to not indict white officers in the demise of African American males in Ohio, Missouri, and New York has intensified the growing issue of mistrust between law enforcement and people of color and resulted in protests across the United States. Law enforcement across the United States has an extensive history in mitigating and dealing with negative public perceptions-specifically among ethnic-minority populations (Ogletree, Prosser, Smith & Talley, 1994). Racial disparity in the criminal justice system prompted the United States

Department of Justice to develop the National Center for Building Community Trust and Justice Initiative. The initiative explores the disconnection between the justice system and communities of color, works to improve the judicial process, and seeks to reduce racial bias (Community Trust, 2014).

Resulting from previous and existing experiences with racism, many African Americans have developed a level of distrust toward European American therapists and developed a cultural paranoia that contributes to the level of distrust creating a barrier to self-disclosing for African American clients (Morris, 2001). Encouraging clients to self-disclose and being open to receiving communication from clients in a culturally respectful manner presents challenges in the assessment and therapeutic phase (Morris, 2001). Cultural paranoia functions as a skill of survival for many African Americans. Morris (2001) notes that understanding cultural paranoia and understanding the difficulty that African Americans have in giving up this mechanism of survival during the therapeutic process is critical in understanding the African American client within their cultural context.

Being oppressed means the absence of choices (Hooks, 1984). In the United States, the normative group includes White; Christian; heterosexual; male; able-bodied; with wealth and resources available to access (Van Voorhis, 1998). The absence of choices stem from the normative group's control of educational, financial, and judicial institutions resulting in the marginalization of access to basic resources. The assessment and treatment of African Americans begins with an understanding of the psychosocial effects of oppression (Van Voorhis, 1998).

The foundation of knowledge in understanding the African American experience is based on understanding oppression and alienation, identity formation, and coping mechanisms (Van Voorhis, 1998). Alienation ensues when people are separated from their culture and forced to take on the oppressor's culture and can result in the individual experiencing deep feelings of anguish. According to Bulhan (1985), research about the identity formation process as a member of an oppressed group reports that functioning in an oppressive society creates a barrier to an individual embracing their cultural identity leading to shame and alienation from the self.

Oppression may also contribute to African Americans experiencing a high level of vulnerability. Feeling vulnerable destabilizes a person's ability to sustain a positive view of self (Brown & Harris, 1978). Feeling vulnerable can also impact an individual's view of their future. According to Brown and Harris (1978), the impact of unpleasant events in the life in vulnerable individuals is intensified because they have little optimism in their ability to recover or replace tangible or intangible resources.

African Americans disproportionally experience social and economic environments that are viewed as triggers for psychiatric malady (Cutrona et al., 2005). Ongoing experiences with systemic oppression continue to impact the African American community. Discrimination, prejudices, and a legacy of slavery continue to have an influence on the social and economic standing of African Americans who are still at the bottom rung of the hierarchical ladder economically, socially, and politically (Carrington, 2006).

In exploring the relationship between economic oppression and depression, Hudson, Neighbors, Geronimus, and Jackson (2012) retrieved data drawn from the

National Survey of American Life to explore the relationship between socioeconomic position (SEP) indicators and Major Depressive Episode (MDE) in African Americans. MDE was assessed at one-year and lifetime intervals using the World Mental Health version of the Composite International Diagnostic Interview (Hudson et al., 2012). The study found an inverse relationship between household income and one-year MDE. The study also found that household income and unemployment predicted an increased chance of MDE and that unemployment was significantly associated with lifetime MDE among African American men at the one-year interval (Hudson et al., 2012). The authors concluded that SEP indicators does not serve as a complete representation of the stressful triggers that African Americans regularly encounter and that further research should be conducted to examine the role that racial discrimination affects the SEP and depression.

Cutrona et al. (2005) conducted research to explore the relationship between neighborhood context and depressive symptoms in African American women. The authors hypothesized that neighborhood context would increase the vulnerability for depression. The authors also tested the prediction that women living in a highly impoverished neighborhood and/or high rates of social disruption have an increased likelihood of experiencing a depressive episode after experiencing drastic life changes compared to women who live in a more benign neighborhood.

The research conducted by Cutrona et al. (2005) consisted of a sample of 720 participants in the age range of 24-80. The researchers interviewed the participants twice, once in 1997 and then again in 1999 with the overall retention being 88% (n = 631). All of the participants resided in rural areas, small towns, or midsized cities in block group

areas in which the African American population was greater than 10%. The participants were also from varying income ranges from being impoverished to being a middle- class African American family (Cutrona et al., 2005). Census data was used to compute economic disadvantage indexes for the identified block group areas and neighborhood quality was based on the participant responses to assessments that were developed to use in the research project which was the Community Dilapidation Scale and the Community Deviance Scale.

Participants were also interviewed and were administered scales to measure depression, negative affect, and negative life events. The results indicated recent onsets of depressive symptoms were significantly higher among participants that lived in socially disruptive and impoverished neighborhoods as compared to those that did not. The results also found that women that reside in impoverished and high-crime neighborhoods are more likely to become depressed after experiencing a negative life event compared to women residing in better areas (Cutrona et al., 2005).

African Americans' experience with inequality and racial disparities may present challenges to an individual's self-worth, value, and esteem (Settles et al., 2010). The authors examined the relationship between depression and racial identity among 379 African American women. To explore three components of racial identity, the authors used the Multidimensional Model of Racial Identity. The three components that were explored are racial centrality- how African Americans identify themselves as it relates to race; private regard-personal judgments about being African American; and public regard-consideration of how society holds negative or positive views of African Americans (Settles et al., 2010). The study found that those that endorsed higher public

and private regard about African Americans reported significantly less depressive symptoms.

African Americans are regularly exposed to intersecting oppressive systems which may lead to higher prevalence of depression (Carr et al., 2014). The authors conducted a study to understand how dealing with specific sources of oppression (sexual objectification, gendered racism, and racist events) contribute to depressive symptoms in African American women. The study also explored how internalizing oppression mediated the three intersecting systems of oppression. Coping with oppression by internalizing its effects refers to the propensity to take personal responsibility for the reason of an oppressive or discriminatory event (Carr et al., 2014).

A sample of 144 African American women (ages 18-72) who had received some form of mental health service from a university-affiliated hospital was used in this study. The measurement tools used in the study include the Interpersonal Sexual Objectification Scale, Schedule of Racist Events-Recent, Racialized Sexual Harassment Scale, and the Beck Depression Inventory-II. The results found that internalizing oppressive experiences (sexual objectification, gendered racism, and racist events) are linked to depression (Carr et al., 2014).

A major part of understanding depression in African American women is considering her social context (Nicolaidis et al., 2010). Violence presents as a significant societal concern with minorities and those living in impoverished areas being disproportionately burdened by its effects (Nicolaidis et al., 2010). Using a sample of 30 African American women with MDD and personal experiences with violent victimization- the authors conducted a qualitative, focus- group study to understand how

the participants' social environment and experiences with violence influence their psychosocial functioning. To screen participants, the Depression Scale of the Patient Health Questionnaire was administered and those that scored higher than 15 and responded yes to one of the two questions that focused on lifetime experiences with lifetime experiences with intimate partner violence (IPV) were considered for the study.

The study found the following common themes: themes related to the individual, the health care system, depression and treatment for depression, and preferences for depression interventions (Nicolaidis et al., 2010). Themes related to the individual include the use of drugs and alcohol to self-medicate although there was a level of awareness that such use exacerbated the problem. Also, many described how their family diminished their mental health issues and encouraged them to cope with their concerns without seeking help as they were just experiencing "growing pains" and could resolve their issues on their own (Nicolaidis et al., 2010).

Themes related to the health care system include complex personal trauma conflicts between elders and medical practitioners; knowledge of oppression that prevented previous generations of African Americans from receiving adequate health care; describing the health care system as "white"; and general mistrust of European Americans (Nicolaidis et al., 2010). One participant verbalized that personal experiences should not be shared with a European American clinician. Another significant theme related to the healthcare system is the participants' negative experiences with the health care system in which they attributed to racism: feeling that clinicians did not spend enough time with them, perceptions that providers did not respect their intelligence, and lack of sufficient explanations about their diagnosis (Nicolaidis et al., 2010).

As it relates to care for depression, participants verbalize the expectancy to be a "strong black woman" and it presents as an obstruction in becoming aware of depression, acknowledging that they are depressed, or being open to seeking care. One participant in the study expressed the difficulty in "being strong every day" and that "African Americans don't learn that it is okay to get treatment" (Nicolaidis et al., 2010). In summary, the participants had a general fear of antidepressants, feared possible addiction to anti-depressants or being "doped-up," were willing to take meds as a last resort, had a preference for self-care, and felt that doctors were in alliance with pharmaceutical companies.

In the themes related to preferences for depression interventions, the participants communicated a consistent preference to have an African American clinician and many refused to participate if their clinician was not African American. The participants also expressed that they wanted depression care that addressed practical life issues and enthusiastically supported programs led by an African American IPV survivor. The implications of the study show that participants were apprehensive of most depression treatment approaches and clinicians that were associated with White systems of care. Service providers should seek to understand and acknowledge the ongoing relevancy of racism and the negative implications of those that have suffered as a consequence (Nicolaidis, 2010).

Historic and ongoing effects of racism and oppression continue to have a negative impact the African American community that has had to cope and adapt to systemic processes that have been developed to create barriers and limitations (Windsor, Dunlap, & Armour, 2012). The impact can be seen in the economic, social, and educational

realms. Oppression impacts one's ability to live in mainstream America and the amount of trauma, resilience, and creativity required can be inconceivable to those who have opportunities and are raised to be employable in mainstream ethnocentric society (Windsor et al., 2012).

Cognitive Behavioral Therapy

Depression is a cross-cultural issue and the psychological community implores a number of approaches to treat depression. Aaron Beck developed a treatment approach known as cognitive behavioral therapy (CBT) based on his research on depression that discovered that depressed clients had negative biases on how they interpreted life events contributing to the development of cognitive distortions (Beck, 1979; Corey, 2005). CBT helps patients recognize the relationship between thoughts, feelings, and behaviors and guides patients through structured learning experiences. The theoretical conventions of CBT are that a person's internal communication can be accessed through introspection; an individual's beliefs have deeply personal implications that can be revealed by the client as opposed to the clinician teaching them (Beck, 1979; Corey, 2005). The goal of CBT is to overcome difficulty by modifying distorted thinking, behavior, and emotional responses.

CBT can be advantageous in multicultural counseling if the therapists understand the core cultural values of the client. Those values can be explored as a way to help an individual become more aware of conflicting thoughts, feelings, and beliefs (Corey, 2005). Exploring an individual's values and fundamental beliefs is an integral component of cognitive behavioral treatment approaches and it is essential that therapists possess a

level of understanding about the client's culture and to be sensitive to their experiences and adversities (Corey, 2005).

CBT is recognized to be an effective modality in treating major depressive disorder and in moderate to severe major depression (Matsunga et al., 2010). In a study using 38 participants with mild Treatment Resistant Depression (TRD), the authors sought to determine if adding a 12-week cognitive behavioral group would improve symptoms of depression and functioning and if those improvements would be sustained after one-year. TRD describes when depressive symptoms do not improve after receiving a minimum of two trials of antidepressant medications from different medication classifications and often, TRD patients often experience limitations in their psychosocial functioning due to ongoing symptoms (Matsunga et al., 2010).

The patients were assessed using the Short-Form Health Survey (SF-36), Global Assessment Functioning Scale (GAF), Dysfunctional Attitudes Scale-Revised (ATQ-R)and the Hamilton Rating Scale for Depression (HRSD) at baseline, termination, and during 12-month follow-up. The study found that at the completion of the CBT group sessions, the GAF and SF-36 scores had increased while the HRSD, DAS, and ATQ-R scores were lowered indicating improved psychosocial functioning and mood symptoms at the end of treatment (Matsunga et al., 2010). In the 21 patients that followed-up after 12-months, improvements in their psychosocial functioning were sustained (Matsunga et al., 2010).

Medication Treatment for Depression

Medication is another common form of treatment to reduce depressive symptoms (Sclar et al., 2012). Antidepressant medication if the one of the most common treatment

modalities for depression as research indicates that antidepressants are effective in treating acute depressive symptoms as well as the prevention of relapse (Donoghue & Taylor, 2000). The rate of depression diagnosis the prescription of antidepressants significantly increased during the last 20 years (Sclar et al., 2012).

Sclar et al. (2012) conducted a study to explore office-based physician visits in documenting a diagnosis of depression and the rate of antidepressants prescription according to race and ethnicity. Secondary data was accessed from the United States National Ambulatory Medical Care Survey from 1992-1997 and 2003-2008. The years of 1998-2002 were not included in the study due to missing ethnicity data.

The results indicate that during the years explored in the study, the rate of depression diagnosis increased by 28% for non-Hispanic Whites; 54.8% for non-Hispanic African-Americans; and 37.5% for Hispanics. The rate of depression diagnosis is aligned with an increase in antidepressant prescriptions which increased 66.2% for non-Hispanic Whites; 69.2% for non-Hispanic African Americans; and 36.7% for Hispanics (Sclar et al., 2012).

Siddique et al. (2012) conducted a study to compare responsiveness results of medication treatment and CBT in young minority women from a low-income area that have been diagnosed with major depression. Their study found that medication was superior to CBT at 6months in those diagnosed with moderate depression, but the improvements was not sustained during the annual follow-up indicating that neither approach was effective in sustaining long-term management of depressive symptoms (Siddique et al., 2012).

McKnight and Geddes (2013) conducted research to determine the implications of adding CBT to TRD patients in the United Kingdom. Study participants were ages 18-75 and 72% of the participants were women. The 469 participants were separated into two groups. One group (n = 234) receiving 12 manualized individual CBT sessions in addition to taking antidepressants and the other group (n = 235) continued with their antidepressant regimen as prescribed by their physician. Study participants were administered the BDI at baseline, 6-months posttreatment and at 12-months posttreatment. Individuals were excluded if they had a bipolar or psychotic disorder, had an issue with substance abuse, were already participating in therapy, or engaged in CBT treatment in the past three years. Results of the six-month outcome indicated an average 50% reduction in depressive symptoms from the baseline BDI score and the 12-month outcome indicated an average BDI score less than 10. According to the authors, adding CBT to TRD treatment results in improved response and remission rates.

Various factors may influence an individual’s responsiveness to antidepressant medication. Schettino et al. (2011) conducted research to explore the correlation between religiosity/spirituality and how an individual responds to citalopram (antidepressant medication). The authors also explored if ethnicity has a role in moderating the relationship between religion/ spirituality and treatment response (Schettino et al., 2011). There have been mixed findings on the role that religiosity/spirituality may have on promoting mental health. It has been argued that religiosity/spirituality protects an individual against the onset of depression and increases access to social supports (Schettino et al., 2011). The authors hypothesized that religiosity/spirituality will be linked to a higher response to citalopram (CIT).

Participants included 148 African American and European American adults with MDD. 64% of the sample was female and 64% were African American. The Hamilton Rating Scale for Depression (HRSD) was used to assess depression at baseline and in weekly intervals. A social support scale was administered at baseline and post-treatment. During Week 3 of the 8-week study, religiosity was assessed using the Religious Involvement Inventory (personal faith subscale) and spirituality was assessed using the Spiritual Well-Being scale (religious well-being subscale).

Study results found no substantial association between antidepressant treatment and spirituality, but did find a significant relationship between treatment response and religiosity. Moderate levels of religiosity responded better to antidepressant treatment significantly better than those with either higher of lower levels of religiosity. The results also indicate that there are no significant ethnic differences in antidepressant medication treatment responses and that social support or ethnicity does not moderate the connection between depression severity and religiosity/spirituality (Schettino et al., 2011).

Culturally biased views or opposition to medication treatment can complicate the use of psychotropic medicines (Jackson, 2006). African Americans have a reduced likelihood of accepting antidepressant treatment than whites and have been shown to prefer engaging in counseling as opposed to medication treatment for depressive symptoms (Jackson, 2006). Stigma and spirituality can be significant influences in African Americans' hesitance in taking antidepressants (Cooper-Patrick et al., 1997).

Givens et al. (2007) conducted a study designed to explore ethnic variances in depression, treatment, stigma, and treatment preference (counseling vs. medication). The study used a cross-sectional survey on the internet to collect information from a final

sample size of 78, 753 participants over a forty-month period. The participants were 74% women and included Whites (68, 319); African Americans (3,596); Hispanics (3,203); Asians/Pacific Islanders (2,794); and Native Americans (841). Significant symptoms of depression were assessed by a computerized screening of the Center for Epidemiological Studies Depression Scale and individuals with scores higher than 22 were asked to participate in an online assessment of their view of depression and preferred treatment (Givens et al., 2007).

The study found that ethnic minorities are less likely to trust that medication is beneficial in treating depression; believed antidepressants are addictive; and that non-pharmacologic approaches including counseling and prayer are effective in treating depressive symptoms (Givens et al., 2007). In regards to treatment preferences- Native Americans and Whites preferred medication to counseling (42% and 41% respectively); 54% of African Americans, 49% of Asians/Pacific Islanders, and 46% of Hispanics favored counseling. The study also found that the clinician's ethnicity was important to all ethnic groups, with African Americans indicating the strongest desire for a clinician of the same ethnicity (Givens et al., 2007).

Culturally Adapted Cognitive Behavioral Therapy

Culturally adapted CBT is an evidenced-based treatment approach that accommodates the attitudes, beliefs, and behaviors of a specific culture (Whaley & Davis, 2007; Ward & Brown, 2015). The application of culturally-adapted CBT methods can be effective in moderating the effects of depressive symptoms in minority groups. The integration of culturally sensitive, evidenced-based treatments can reduce treatment disparities and better serve minority populations (Aguilera, Garza, & Munoz, 2010). The

authors conducted a study to determine the impact that culturally sensitive adaptation of group CBT would have on depressive symptoms experienced by Latinos. Participants engaged in 16 weekly, 1.5 hour sessions.

The group treatment that consisted of four modules: cognitive restructuring, health, behavioral activation, and interpersonal skills training (Aguilera, Garza, & Munoz, 2010). The Spanish- speaking group had continuous enrollment with the maximum number of group size being 11 participants. Participant progress was tracked via the CES-D before each session and administered the Mood Screener for Depression in the first session of each of the four modules. Culturally relevant terms and paraphrases were used to cultivate a rapport amongst the group members and facilitators. The results found that although there were problems with consistent attendance and completion of homework assignments, there was a 6.5 point average reduction in CES-D scores and an increased sense of efficacy in practicing the skills taught in therapy.

Culturally adapted treatment may be more familiar with the cultural experiences of ethnic minority patients as compared to standardized treatment approaches and may also be more effective in treating psychological distress (Kohn et al., 2002; Whaley, 2007). The authors conducted a study that modified the structure of a CBT group therapy manual based on therapeutic approaches that either directly or indirectly addressed explicit facets of African American culture. The authors hypothesized that the culturally adapted treatment would lead to a reduction in symptom severity when compared to treatment that was not culturally adapted (Auguilara et al., 2010). The manual version of the CBT depression group developed by Munoz and Miranda in 1983 consists of 3 four-session cognitive behavioral modules that focus on relationships, cognitions, and

activities. The first module is repeated at the end of the three modules-totaling 16 group sessions with new patients being acquainted with ongoing groups at the beginning of each four-session module.

The culturally adapted version of the manualized version of the CBT group included both structural and didactic adaptations. Structurally, the group was closed and limited to African American women with MDD. In addition, meditation was added to treatment and a ritual was conducted after the 16-week intervention was complete. Change was also made in the language, such as using the term suggested by participants- "therapeutic exercise," instead of homework. The group curriculum also included illustrating concepts using African Americans and narratives from African American literature. Another adaptation included adding culturally relevant sections of content that: creating healthy relationships, family issues, spirituality, and identity as a way to address issues that are relevant to treating depression in the targeted population (Kohn et al., 2002).

The mixed methods study began with ten participants in the culturally adapted CBT group with eight completing all group sessions. The participants of the culturally adapted group were matched to women who had participated in previous treatment in the traditional CBT group based on their demographics. Group participants were administered the BDI pre-and post-treatment and the culturally- adapted group session were videotaped and coded for themes and the affective tone of the sessions.

The results indicate that both groups had a reduction in symptom intensity as rated by the BDI. The culturally adapted group BDI scores reduced 12.6 points on average pre- and posttreatment in comparison to an average reduction of 5.9 points in the

traditional CBT group. The culturally adapted group indicated six primary themes: suicidal ideation, taking care of family members, substance abuse, experienced racism in social services, abuse from significant others, and being socially isolated from others (Kohn et al., 2002). The authors also identified the generalized predominant affective tone being intense irritability as opposed to sad or dysthymic mood. The current climate demands evidence for efficacy in treatment and it is important to understand how culturally-specific interventions can work for the targeted populations.

Although CBT is known to be a highly used treatment approach in the western world, this approach it is not commonly available in the developing countries (Naeem, Ayub, Gobi, & Kingdon, 2009). The authors argue that differences in culture may influence the psychotherapeutic process and such therapy may need to be adapted based on the cultural needs of a country. The authors conducted a qualitative research study to establish if CBT is an accessible and acceptable treatment approach for depression in a developing country. Their research was compromised of a succession of studies to as a way to develop a CBT manual to treat depression using depressed patients, psychologists, university students, and field observations. In-depth interviews were conducted to determine themes and subthemes that will help guide the development of a culturally sensitive CBT manual (Naeem et al., 2009).

Culture, capacity and circumstances, and cognitions and beliefs were the three major themes identified. Some subthemes of culture include religion/spirituality, family, cultural expression of symptoms, and traditional healing practices vs. faith healers. Subthemes of capacity and circumstances include the role of gender, age, and educational level. Cognition and belief subthemes include beliefs about the cause of mental illness

and beliefs about treatment, health systems, and healing and the healer. The results of the research led to the development of a culturally adapted CBT manual for treatment in Pakistan to be used in future studies.

Naeem et al. (2014) conducted a follow-up study explore the effectiveness of a culturally adapted CBT depression treatment manual in Pakistan that the authors developed as a result of the previous study. Participants were referred by their primary care physician and asked to engage in the study. The study participants were randomly assigned to either the intervention group that received a combination of CBT and antidepressants or the control group that received antidepressants alone. The study consisted of a total of 34 participants with 17 patients in each group. Financial status was the only substantial demographic distinction between the groups. The Hospital Anxiety and Depression Scale (HADS) and Bradford Somatic Inventory (BSI) were assessed pretreatment and posttreatment to determine changes in depressive, anxiety, and somatic symptoms respectively (Naeem et al., 2014).

The cultural adaptions of the CBT treatment manual include engaging patients in nine treatment sessions to reduce the burden and travel costs; therapists concentrated on physical symptoms to focus on the importance of the association between physical symptoms to thoughts and moods; using culturally relevant jargon during therapy sessions; allowing a family member to accompany patient to all treatment sessions; and using culturally and spiritually relevant folk stories and examples from life were used to clarify issues. Naeem et al. (2014) hypothesized engaging in culturally-adapted CBT in conjunction with antidepressants would supersede the benefit of antidepressants alone among group participants. The results indicate statistically significant improvements in

the therapy group on the HADS and BSI assessments as compared to the antidepressant-only group. Evidence suggests that culturally-adapted CBT is an effective treatment approach for non-Western cultures (Naeem et al., 2014).

Fujisawa et al. (2010) developed an individual CBT model program with cultural characteristics as a result of their findings of limited adoption of CBT in Japan's clinical practice. According to the authors, CBT is grounded in Western perceptions of depression and there is a lack of practical application of CBT among depressive Japanese patients (Fujisawa et al., 2010). As noted by the authors, the cultural adaptations included an emphasis on problem-solving and interpersonal concerns.

A total of 27 participants, aged 18-60, were referred by their psychiatrists and participated in manualized 50 minute/16-week culturally adapted CBT treatment for Japanese. The study consisted of 18 female and 9 male participants. The participants were assessed using the Beck Depression Inventory-II (BDI-II), Dysfunctional Attitude Scale (DAS-24), Quick Inventory of Depressive Symptomology-Self-Rated (QIDS-SR), Hamilton Depression Rating Scale (HAMD-17), Subjective Well-Being Inventory (SUBI), and the WHO Subjective Well-being Inventory (SUBI) pretreatment and posttreatment (Fujisawa et al., 2010).

The study results indicate a preliminary confidence in the application of CBT to treat depression in Japan (Fujisawa et al., 2010). The post-treatment results for BDI-II show a mean decrease of 20.8 or a 64% improvement in depressive symptoms. Results also indicate a 66% improvement in symptoms as rated by the HAMD-17 and a 19% improvement according to the QIDS-SR. Mean DAS scores decreased by 20.9, the GAF ratings improved by 58%, and global functioning ratings increased by 58% post-

treatment. The positive outcome for CBT provided in this study is a fundamental step for implementing CBT into Japanese clinical settings and may potentially impact therapists in other countries that provide services to individuals of Asian ethnicity diagnosed with depression (Fujisawa et al., 2010).

According to Interian, Allen, Gara, and Escobar (2008), there are limited studies that examined CBT for MDD among the Hispanic population. The authors argue that the inadequate research underscores the expectation to broaden research to include Hispanics and other ethnic minorities as a way to decrease disparities in research (Interian et al., 2008). They conducted a study to evaluate a cultural adaptation of individual CBT for 15 Hispanic primary care patients (14 women and one man) between the ages of 18-65 with a diagnosis of MDD. Exclusions were made if subjects were actively participating in psychotherapy, abused substances, taking antidepressants, had a psychotic diagnosis, or an unstable medical illness. The Beck Depression Inventory-Spanish (BDI-S), Beck Anxiety Inventory (BAI), Patient Health Questionnaire-15 (PHQ-15), and the Structured Clinical Interview for Axis I Disorders (SCID) was administered at baseline, after treatment was completed, and during the follow-up sessions held six months post-treatment (Interian et al., 2008).

Study participants engaged in one-hour weekly sessions and in which all measurement tools and clinical interventions were administered in Spanish (Interian et al., 2008). The first six sessions of therapeutic interventions concentrated on behavior and the final sessions concentrated on psychotherapeutic interventions (Fujisawa et al., 2010). Another cultural adaptation includes the use of an ethno-cultural assessment to determine information such as the number of years in the US, whereabouts of family, and adaptation

to migration. During the therapy sessions, overtly warm and positive interactions were emphasized, common cultural phrases were used, family-oriented activities, were used in recognition of the strong cultural emphasis on family, and common values such as respect and "putting one's part" were considered during the treatment process (Interian et al., 2008).

Results indicate that 67% of the participants were responsive to the culturally adapted treatment as there was a 50% or greater reduction in BDI. Results also indicate that BAI scores reduced an average of 18.9 points post-treatment and remained reduced at 18 during six months post-treatment. The mean PHQ-15 scores reduced by 6.2 points post-treatment and remained reduced 5.5 at follow-up. BDI-S mean reduction was 19.3 post-treatment and 18.2 at the six-month follow-up session. The results of the pilot study indicate that cultural adaptations of CBT may be clinically beneficial for patients. The authors recommend that subsequent cultural adaptations should be guided by their study (Interian et al., 2008). The exploration of the effectiveness of traditional and alternative depression treatment approaches is essential in gaining a greater understanding of the most effective methods for culturally diverse populations.

Africentric Worldview

Worldview is comprised of interests, values, and perspectives that influence perceptions and behaviors (Sue & Sue, 2008; Koltko-Riveria, 2004). Worldviews can vary amongst cultural groups and can help define how individuals feel, view, think, perceive, and experience (Myers, Montgomery, Fine, & Reese, 1996). According to Sue & Sue (2008), worldview is interconnected to one's cultural background and many diverse groups embrace worldviews that contrast than the worldview of the dominant

culture. Helping professionals should be aware of differences in cultural worldviews as not to respond according to their personal values, assumptions, and perspectives (Sue & Sue, 2008).

Worldview can be defined as "a way of describing the universe and life within it; a given worldview is a set of beliefs that includes limiting statements and assumptions regarding what exists and what does not (either in actuality, or in principle); what objects or experiences are good or bad; what objectives, behaviors, and relationships are desirable or undesirable; and defines what can be known or done in the world" (Koltko-Rivera, 2000, p. 2).

As it relates to worldview, Africentric worldview is defined as values, beliefs, and assumptions that are reflective of traditional African values experienced by persons of African descent (Belgrave, Townsend, Cherry, & Cunningham, 1997). As defined by Belgrave and Allison (2006), the seven holistic dimensions of Africentric worldview include:

*Spirituality: T*he belief in an omnipresence or greater force with an emphasis of the spiritual over the material.

Collectivism: Emphasizes interrelatedness and connection to others and group needs take precedence over individual needs. People are inter-dependent and the survival of the group is of the highest importance.

Time Orientation-: The past, present and future all have equal value and importance.

Orality: Oral communication is preferred and carries equal weight to what is written.

Sensitivity to affect and emotional cues: Being sensitive and in tune to the emotional needs and feelings of others that is reflected in verbal and non-verbal behavior.

Verve and rhythm: Emphasizes creativity using visual, auditory, tactile, and motor channels simultaneously. One gains knowledge through symbolic imagery and rhythm.

Balance and harmony with nature: Recognizing the need to have balance between an individual's mental, physical, and spiritual state. One should always be in harmony with nature.

It is believed that the identified dimensions helped sustain Africans that had been enslaved and held onto the dimensions as a way to survive in racist and oppressive environments which has been passed on to subsequent generations (Belgrave & Allison, 2006).

Given the strong connection between a person's worldview, and his or her behaviors, Neblett, Seaton, Hammond, and Townsend (2010) conducted a study to examine underlying mechanisms between Africentric worldview, depression, and perceived stress using 112 college students (36 men and 76 women). According to the authors, individuals with an Africentric worldview are able to mentally adjust when encountering perceived stress is due to the shielding nature of having an Africentric worldview (Neblett et al., 2010). The study found that participants that endorsed lowered Africentric worldview have an increased likelihood of developing depressive symptoms during stressful periods in comparison to participants that endorsed higher Africentric worldview.

Walker, Alabi, Roberts, and Obasi (2010) conducted a study to explore the relationship between an individual's worldview and their reason for living. The study

consisted of African and European American participants and used the Worldview Analysis and Reasons for Living Inventory. According to the authors, advancements in suicide research are best accomplished in cross-cultural samples given the ethnic group differences in suicidality (Walker et al., 2010). The authors hypothesized that the participants would have a variation in scores based on race. Hopelessness and depression are commonly associated factors with suicide but worldview might mitigate the effect of those risks (Walker et al., 2010). Additionally, cultural worldview can shape or diminish an individual's decision to choose life as worldview determines how individuals cope within their reality (Myers, 1988).

The study found similar levels of hopelessness and depressive symptoms among the participants and noted that African Americans identified increased reasons for living than the European American participants. Results also indicate that African Americans with a less Africentric worldview also reported increased hopelessness. Endorsing an Africentric worldview can have an impact on suicidal risk and serves as a moderating factor in the relationship between cultural status and suicide (Walker et al., 2010). The study provided insight on the interconnectedness of cultural worldview and reasons for living and those results can contribute to understanding cultural differences as it relates to the complex issue of suicide.

Having and Africentric worldview may significantly impact African Americans' psychological adjustment and any aberration from an Africentric worldview might contribute to psychological dysfunction (Akbar, 1991). Individuals who embrace an Africentric worldview may have higher levels of esteem, confidence, and purpose (Myers et al., 1996). Difficulties in psychological functioning may arise when an individual has

to function in a society that embraces a worldview that conflicts with their core values and beliefs. American culture is often based on Eurocentric worldview and can create conflicts for individuals with differing cultural viewpoints (Wilby, 2009).

African-Centered Therapy

Historically, counseling and psychology has been dominated by the teaching and theories of European psychologists and primarily rooted in Eurocentric ideals and cultural norms (Sue & Sue, 2008). Observing limitations of traditional psychotherapeutic approaches and mental health service delivery, African-centered psychologists have established African-centered therapeutic approaches as a framework by which to deliver services (Queener & Martin, 2001). Some African American psychologists argue that engaging clients in theories that are based on middle-class white populations led to a mental health system in which African Americans underutilize services, terminate from services early, are misdiagnosed, and receive suboptimal treatment (Queener & Martin, 2001). In providing effective treatment to African Americans, cultural values and the degree of adherence to the identified values must be considered and integrated into their treatment plans (Constantine et al., 2009).

African-centered psychologists' reason that the experience of African Americans is considerably different than European Americans which merits the need for psychological approaches that address behaviors, experiences, and mentality of African Americans (Anderson, 2003). African-centered psychologists discovered limitations that the traditional application of Eurocentric normative behavioral values and patterns had to the African American experience in a therapeutic setting. Traditional psychology is based on Eurocentric norms without consideration to the experience and norms of African

Americans. Lack of consideration results in less than reliable psychological findings and implications because the mental motivations and cultural values upon which traditional psychology is founded differ from African American behavioral norms (Anderson, 2003).

African-centered therapeutic approaches do not dismiss the utility and value of traditional psychology, but presents treatment modalities that will increase knowledge and understanding of the psychological functioning of African Americans according to the dimensions of Africentric worldview (Tarnes, 2011). African Americans and European Americans function under different processes that represent fundamentally different realities and the cultural differences reflect their distinct approaches to conceptualizing, organizing, and experiencing reality (Anderson, 2003).

NTU Psychotherapy

NTU (pronounced "in-too") psychotherapy is a therapeutic approach developed by Fredrick Phillips (1990) and is grounded in core ancient African principles and Africentric worldview. Ntu is a Bantu (Central African) term describing a universal and unifying force that is core of our existence and life (Phillips, 1990; Washington, 2010). NTU is a spiritually-based African-centered therapeutic approach with the primary goal being assisting a person in becoming balanced within a shared energy and spirit that is aligned with the natural order (Phillips, 1990). When people at one with their mind, body, and spirit- they experience alignment from within and are at peace- even if external forces that surround them are fragmented (Phillips, 1990).

The second goal of NTU psychotherapy is supporting the client in engaging in the Principles of the Nguzo Saba as a guideline for healthy living (Gregory, 1997). The Seven Principles are as follows:

Umoja (Unity): Striving for and maintaining unity in the family, community, and nation.

Kujichagulia (Self-Determination): Defining, creating, and speaking for one's community.

Ujima (Collective Work and Responsibility): Building and maintaining one's community and to solving problems together.

Ujamaa (Cooperative Economics): Building and maintaining economic enterprises and profiting from them collectively.

Nia (Purpose): To collectively build and develop one's community and to be in harmony with one's spiritual (divine) purpose.

Kuumba (Creativity): Doing as much as one can, in the way that one can, to ensure that one's community is better than it was inherited.

Imani (Faith): To wholeheartedly believe in one's parents, teachers, leaders, and people.

In NTU psychotherapy, the mental healing process is considered to be a natural process. The therapist's role is to assist the client in becoming mentally, spiritually, and physically aligned (Phillips, 1990). The therapist's goal consists of having a full awareness if their client's spirit and guiding the client to become more aware, realign themselves, and integrate their increased knowledge (Gregory, 1997).

Phillips (1990) presents five phases of NTU psychotherapy: harmony (becoming harmonious with the forces of life); awareness (increasing knowledge of self); alignment (uncovering and reconciling core neurotic fear or anxiety); actualize (practicing and experimenting with new attitudes and behaviors); and synthesize (integrating knowledge

gained through the process). The first phase establishes a shared level of awareness and consciousness between the counselor and the client; in the second phase, the counselors assist in differentiating between their individual needs and boundaries as well as the greater needs and boundaries of others; during the third phase, clients are encouraged to challenge their anxieties and fears; during the fourth phase, clients begin to explore different views and behaviors; and in the final phase, clients are guided to incorporate acquired knowledge in the physical, mental, and spiritual realms (Phillips, 1990).

In NTU therapy, the treatment phases are circular rather than linear, are interconnected, and holistic as a technique that is used in one phase can be meaningful for the client in a different phase (Phillips, 1990). NTU psychotherapy emphasizes the interconnection between internal and external factors that impact an individual's ability to cope with problems with their daily lives (Phillips, 1990; Gregory, 1997).

In a case illustration of an African American college freshman provided by Wynn and West-Olatungi (2008), the counselor uses NTU therapy in the treatment process. The client presented with feelings of isolation as a result of his sexuality. He had difficulty integrating his different friendship groups and his family to develop a supportive network that would allow him to be true to his self-identity. With the guidance of NTU psychotherapeutic principles, the counselor assessed the client within his cultural context and guided the client in finding balance in his physical, social, and spiritual processes (Wynn and West-Olatungi, 2008). The client initiated the termination of his case indicating he achieved his treatment goals.

Ubuntu Psychotherapy

Ubuntu is an Nguni (southern African) term that translates as personhood or humanness. Ubuntu is grounded on a philosophy and worldview that places an emphasis on collectiveness, social harmony, cohesion, and interdependence (Van Dyk & Nefale, 2005; Washington, 2010). The term Ubuntu means "I am because we are" and emphasizes the importance of community being a primary issue while encouraging one to also gain a greater understanding of our individual self (Wilson & Williams, 2013). In the spirit of Ubuntu, a strong emphasis is placed on kinship that takes positioned horizontally which includes all of the living and vertically which includes the dead and individuals not born (Mbiti, 1969). Acknowledging ancestors is a daily native practice of African people recognizing there is a level of connectedness amongst individuals, nature, and God.

The Ubuntu model of psychotherapy is an integrative approach that does not discount Western theories and treatment modalities, but adapts those approaches to individual's specific needs (Van Dyk & Nefale, 2005). Ubuntu therapy is a client-centered approach that seeks to understand the client from their personal worldview. This approach seeks to modify the treatment approach to fit with the client's specific challenges (Van Dyk & Nefale, 2005).

There are three dimensions of Ubuntu therapy. First, the context of the client's relationship with God and ancestors is explored and the therapist should determine how that relationship is characterized (Van Dyk & Nefale, 2005). During second dimension of Ubuntu therapy, the therapist explores the interrelationships of family, group, and community and explores how those relationships could be "characterized by feelings

ranging from low self-image, low self-confidence, dependency, threatened feelings, anxiety, anger, and self-destructive feelings" (Van Dyk & Nafale, 2005, p. 57). During the process of engaging in Ubuntu therapy, the client begins a healing process that promotes consciousness and empowerment. The third dimension explores the client's interpersonal relationships that can consist of feelings of rejection, power struggles, interdependence, or rigidness (Van Dyk & Nefale, 2005). During this level, the therapist works to help the client build more positive interpersonal relationships which then helps the client to feel more valued and trustful. Ultimately, the goal of Ubuntu therapy is to aid in addressing client conflict in various aspects of their life and to help them work through resolving those conflicts in and move toward the spirit of Ubuntu (Van Dyk & Nefale, 2005).

Therapeutic techniques that can be used in the different phases of Ubuntu therapy include life script, telling the story, or burning platform. Life script allows the client to explore messages that have shaped an individual's behaviors and understanding of how they should behave or what they should believe (Van Dyk & Nefale, 2005). The therapist can help the client gain insight on the personal issues that they have with their life script and assist the client in writing a reframing how they view their life and experiences using the Ubuntu philosophy. Telling the story allows the client an opportunity to talk about their problems from their personal perspective and allows the therapist a chance to analyze the client's circumstances and determine where the client is/has experienced the most conflict (Van Dyk & Nefale, 2005). Adaptive reframing that occurs during Ubuntu therapeutic process can help the client experience total humanness and joy (Van Dyk &

Nefale, 2005). This process allows for of resolving the past in a way that is accordance with Ubuntu values.

In a case illustration provided by Van Dyk and Nefale (2005), an African female student at the university presented with concerns surrounding conflict with her family that resulted from her identification with a more Western way of functioning compared to her parents' adherence to traditional cultural values and practices. The therapist aimed to understand levels of conflict experienced by the client and explored those levels during treatment. The mismatch between the cultural views of the client and her parents was emphasized and the therapist helped the client explore and conceptualize her feelings that ranged from loneliness to feeling misunderstood by others. The client's ego functioning was empowered and she was enabled to address the conflict she was feeling with her cultural expectation of being interconnected with her family.

BSA Psychotherapy

Developed by Linda James Myers, BSA is a holistic therapeutic approach based on optimal theory. BSA seeks to help people move towards an optimal conceptual system by developing the client's capacity for self-healing and sustained throughout life toward the realization of their full potential (Myers, 1988). Like other cognitive therapies, BSA emphasizes rational thinking but utilizes a transcendent system of reasoning that is rooted in a specific cultural and historical context.

This approach works to allow the client to explore a worldview that is aligned with growth by comparing and contrasting the impact of embracing optimal versus suboptimal belief systems (Queener & Martin, 2001). A cultural groups' understanding of their nature of being and cultural values contribute to how they make sense of their

reality (Myers, 1988). The goal of BSA therapy is to enhance the clients' quality of life by helping them structure a maximally positive worldview and an optimal level of consciousness. The therapist works with the client on exploring their view of self, view of others, view of self in connection with others, and their values. BSA seeks to guide the client to an increased level of self-knowledge and self-consciousness as a way to help them feel empowered to make personal changes and cope with challenges that are more in-line with an optimal belief system.

The philosophical parameters of an optimal belief system and worldview originate from ancient African cultures and are viewed "as optimal because of its thrust toward the achievement of peace, happiness, and positive interpersonal relationships" (Montgomery, Fine, & Myers, 1990, p. 38). The optimal belief system is focused on harmony and some of the core principles of this approach include:

Self-knowledge: Gaining a deeper understanding of self.

Spiritual Development: The quality of one's relationship/connections to a higher being.

Intrinsic Self-Worth: Understanding of one's divine purpose and challenges.

Extended Self-Identity: Understanding the self in-relation to others and the responsibility that one has to the self, others, ancestors, and future generations from an integrated connectedness.

Di-unital Logic: Developing a sense of reasoning based on the balance and view of both good and bad.

Holistic Worldview: Understanding that all aspects of human functioning is in harmony with nature and the universe as there is an inseparable relationship between the balance of physical, spiritual, social, and psychological.

In the first phase of BSA therapy, the therapist examines the client's current belief system relative to the optimal conceptual system and assesses how much change, if any, the client desires to make (Myers, 1988). The client's current state of functioning is explored through the presenting problem in terms its underlying assumptions or conceptual framework. Thorough understanding of those assumptions entails examining their utility and efficacy according to the client's personal history, goals, and level of consciousness (Myers, 1988). The client is encouraged to become a critical thinker and to question and challenge assumptions. The desire to increase self-knowledge must come from within the client, but once initiated, the process becomes heuristic (Myers, 1988).

The second phase of BSA therapy explores the client's worldview and introduces Africentric worldview which is more optimal. Understanding a client's worldview may help the therapist have increased insight into the client's behaviors, thoughts, and feelings facilitate progress in the therapeutic process (Montgomery, Fine, & Myers, 1990). Guiding the client to move toward a more optimal worldview fosters improvement in the clients' overall psychosocial functioning and view/understanding of the world.

In the third phase, the client continues to move toward increased self-knowledge and awareness and relies more on their inner knowledge allowing therapy to assist in the healing process (Myers, 1988). Self-awareness leads to the development of more conscious behaviors and decision-making thus contributing to ongoing personal growth and development. The optimization process is dialectical and any negativity that occurs is

viewed as an opportunity for growth and increased self-knowledge, revealing aspects of oneself and one's beliefs that need strengthening (Montgomery, Fine, & Myers, 1990). Moving toward optimal functioning and relying less on functioning according to the suboptimal worldview is a process guided by the client. According to Myers (1988), the therapeutic process is successful when the client's esteem increases resulting from increased awareness of intrinsic self-worth, the client feels empowered to define their perception of reality, and the client becomes more spiritually connected.

In a case study, using BSA as a therapeutic approach, Myers (1988) noted how the application of this treatment approach is effective in enhancing client functioning. The individual in the case study is a middle- aged African American female seeking therapy to help her address her issues with depression. The woman had been divorced two times and one specific aspect of her treatment was her intimate relationships in which she experienced insecurity and manipulation. She was exposed to suboptimal socialization practices and an externalized sense of self and reality contributing to her feelings of depression. She was not living in accordance with her true values and beliefs or enhanced her feelings of self-worth with the support of her therapist, the client was able to use her negative experiences to higher consciousness, practice forgiveness of self, and increase her self-knowledge as she worked toward the optimization process.

In another case study using BSA, a married, African American man three was experiencing difficulty coping with oppression, harassment, and discrimination on the job. He was also a target of retaliation as a result of a legal suit against his place of employment. He was diagnosed with post-traumatic stress disorder and depression. Therapy was focused on improving his coping skills, helping him work through the issues

caused in his family as a result of his reaction to the pressure he had been experiencing at work, and overcome his feelings of hopelessness and helplessness. Therapy was designed to help the client restructure his thinking about the oppression he was experiencing and to reinforce his faith as a way to create awareness and understanding about what he needed to do. He was able to place meaning and value of the situation in its proper context and was empowered to remove himself from the situation, continue his stand for justice with reduced stress and increased peace of mind. Increased self-knowledge and self –worth helped the client develop a new conviction and avoid giving power to external forces.

Summary and Conclusions

Worldview shapes one's belief system and the way an individual functions in society. Specifically, for African Americans, as well as other cultures, a suboptimal worldview can prove to be detrimental to one's psychosocial functioning as it significantly contrasts with core African principles that have an innate presence based on ancestry. Understanding one's worldview may have a significant impact on and how the individual responds to treatment. In the therapeutic process, focusing on moving an individual towards a more optimal conceptual system and worldview could result in buffering the mental impact of functioning in a Eurocentric society. Mental health symptoms may be lowered through cognitively reframing clients' beliefs about being African American and society's regard of African Americans (Settles et al., 2010). BSA is the selected African-centered therapeutic approach for this study due to the holistic nature and emphasis on worldview. Additionally, BSA is the only African-centered therapeutic approach that is driven by a specific theoretical framework- optimal theory.

Further, BSA consists of a specific measurement that measures the construct of worldview which has been utilized in other African-centered research studies.

Depression is a prevailing issue in the African American community. There is minimal significant research on depression on African Americans, culturally relevant therapeutic approaches, and African-centered therapeutic approaches. With mental health treatment providers recognizing the relevance and need for culturally-specific treatment approaches, this literature review found significant disparities in current research on how to provide treatment services while recognizing and adapting to specific cultural differences. There is also a significant disparity in research on how utilizing African-centered therapeutic approaches can contribute to the healing process. This study will fill a gap in research on the effectiveness and outcomes of treatment provisions for African Americans.

Chapter 3 will provide information on the research methods that will be used in the study including research design; sample population, procedures, and design; instruments used; detail the data analysis plan; identify potential threats to validity; describe ethical procedures that will be utilized in this study.

Chapter 3: Research Method

Introduction

The purpose of this quantitative study was to learn about the provision of culturally relevant therapeutic services. More specifically, the goal was to provide treatment outcome data that would yield insight on the impact of African-centered therapy (BSA) on depressive symptoms and Africentric worldview. This chapter will provide information on the research design and rationale, methodology, the procedure for accessing and analyzing the archival data, ethical procedures, and threats to validity and reliability.

Research Design and Rationale

This quantitative study utilized a paired samples *t* test to analyze the impact that African-centered therapy (BSA) had on depressive symptomology and Africentric worldview. This study used pre-treatment scores and 1-year posttreatment scores. The independent variable was the time of assessment before engaging in African-centered therapy; Africentric worldview and depressive symptoms were the dependent variables.

Archival data were used, including the demographic information of the participants: gender, age, education level, employment status, income, and marital status. Also analyzed were the results from the Symptom Checklist-90-Revised (depressive subscale results) and the BSAS, both of which were collected at intake and after receiving a year of treatment. Quantitative design was appropriate for this study as the archival data to answer the research questions as the measurement instruments provided scores that could determine if there was an increase or reduction in the results. Quantitative methodology provided a means by which individual characteristics could be

measured and is fundamental to all facets of psychology (American Psychological Association, 2015). There were no time constraints for this study**.**

Methodology

This section covers the following topics: participants, sampling procedures, methods used for data collection and data analysis.

Participants

The voluntary participants that provided consent in this study received outpatient mental health treatment was provided by a community mental health agency in the Midwest, to which provides services based on The agency's consent for data use was approved by the Walden University IRB prior to data collection.

The study consisted of 38 men and women whose age ranged from 19-65 years. See Chapter 4 for a table of the complete demographic data.

Sampling Procedures

A convenience sample of archival data from a mental health agency in the Midwest was used to complete this study. Data included participants that have completed the Symptom Checklist-90-R (SCL-90-R) along with the BSAS according to the time frames indicated-during intake and after one-year of receiving treatment services from 2012-2015. Data was excluded from individuals that dropped out of treatment or study participation. To calculate the minimum sample size, Lenth's (2009) power computer software determined that that study needed to utilize the data of 25 participants.

Procedures for Recruitment, Participation, and Data Collection

This study used an archival data set with permission from the principal investigators. The original data collection is described below. At the time of intake,

outpatient clients that were self-referred or referred by outside agencies were provided an opportunity to participate in a study conducted by a faculty member from a local university and the agency's clinical director. Prior to data collection, the faculty member and clinical director obtained IRB approval from the local university.

The purpose of the previous study at the agency was to evaluate the effectiveness of BSA with African American clients. Individuals were given a consent form that provided them with specific information regarding the study's purpose, the procedure, risks and discomforts, benefits of participation, information on anonymity, information on their right to refuse or withdraw from study participation, and information on where to direct any questions about study participation.

For the larger study, when the individuals agreed to study participation, they completed a demographic form and a series of assessments including the SCL-90-R and the BSAS. These data were coded and filed in a locked and secured location. The coded assessments contain no identifiable participant information. The data from the assessments was entered into a secure database by a research assistant according to the coded number on the assessments. Permission to utilize the data collected by the agency was obtained from the clinical director who signed the Walden Data Use Agreement (see Appendix A).

In accordance to the agency's philosophy, participants were provided with therapeutic services based on BSA. The master's and doctoral level therapists that provided outpatient services to the participants trained and received ongoing supervision on this treatment approach and on how to engage clients using this specific method.

Among other measurement tools, participants completed the SCL-90-R and the BSAS: at the time of intake with an intake worker and after receiving 1 year of therapeutic services from the agency during an annual review with their identified therapist. This agency is the only known agency that provides services based on BSA, which is the specific therapeutic approach being researched in this study. The participants received at least 12 treatment sessions.

Instrumentation Psychometrics

The measurement tools used in this study were selected by the agency providing access to the archival data. The measurement tools were appropriate for this study as they provided data necessary to determine the relationship between African-centered therapy, depressive symptoms, and Africentric worldview. Depressive symptoms were measured using the Depressive Subscale of the Symptom Checklist-90-Revised. Africentric worldview was measured using the BSAS.

SCL-90-R. Developed by Leonard Derogatis (1977), the SCL-90 is a self-report psychological assessment. A revised version was released in 1994 (SCL-90-R) containing 90-items, the inventory takes about 12-15 minutes to complete and asks individuals to indicate the frequency of each indicator for the last seven days. There are five descriptors on a Likert-type scale that range from 0 (*not at all)* to 4 (*extremely*), indicating the significance of discomfort each symptom has caused in the last seven days.

The SCL-90-R seeks to identify symptomology and assess specific and general changes in symptomology to aid in diagnoses. The test has been normed on individuals aged 13 and older within four groups: adult psychiatric inpatients and outpatients, adult non-patients, and non-patient adolescents. The SCL-90-R measures nine symptom

dimensions: anxiety, depression, hostility, interpersonal sensitivity, obsessive-compulsive, paranoid ideation, phobic anxiety, psychoticism, and somatization. Higher scores on subscale measures indicate greater psychological distress in the identified area (Derogatis & Unger, 2010).

There are questions on the test that are not scored in any of the dimensions and are not included in the quantitative evaluation. Three global scores are also acquired to provide greater depth of the client's overall assessment: Global Severity Index which is the average of all 90 items; Positive Symptom Total indicates the total of symptoms experienced; and the Positive Symptom Distress Index is the average of experienced symptoms (Derogatis, 1977; Prinz et al., 2013).

The SCL-90-R is established to have satisfactory internal consistency and test-retest and the reliability is remarkably high (Derogatis & Unger, 2010). Alpha coefficients (internal consistency) are between .77 for psychoticism and .90 for depression and the test- retest (1-week apart) correlation coefficients are between .78 for hostility and .90 for phobic anxiety (Derogatis & Unger, 2010; Prinz et al., 2013). Ayalon and Young (2009) examined the tool with a sample of 70 African American and 66 European American college students to acquire information regarding the reliability of the SCL-90-R in African Americans. The study found a Cronbach's alpha to range from .77-.86 for African Americans, with the median being .86.

Given the adequate validity and reliability of this tool and the purpose of this research, the depression subscale of the SCL-90-R was chosen to rate the severity of depressive symptoms of the participants. The depression subscale of the SCL-90-R consists of 13 items to assess a wide range of clinical depression symptoms (See

Appendix B). The retest reliability of the depression subscale is .82 over a one week period (Derogatis, 1977; Derogatis & Unger, 2010). The depressive symptom ratings have been found to differentiate between patients with primary and secondary depression (Derogatis, 1977; Derogatis & Unger, 2010). The depression factors of the SCL-90-R are significantly correlated with other depression assessments including the Beck Depression Inventory (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961), the CES-D Depression Scale (Radloff, 1977), and the Hamilton Depression Rating Scale (Derogatis, 1977).

BSAS. The BSAS was developed by Linda James Myers in 1990 to establish a reliable and valid method of assessing an individual's adherence to an Africentric worldview according to optimal theory (Montgomery, Fine, & Myers, 1990). The BSAS is appropriate for this study as it measures an individual's adherence to Africentric worldview. The BSAS was based on a pilot study using a 20-item survey to determine Africentric beliefs of mothers (Fine, Schewebel, & Myers, 1985). Revisions were made to the questions improve the usefulness, comprehensiveness, and validity of the scale of measurement. The BSAS consists of 31 items that reflect beliefs that are Africentric (optimal) or non-Africentric (suboptimal). The items are rated using a five-point Likert scale that ranged from 1 (*strongly disagree*) to 5 (*strongly agree*) (See Appendix C). The questions on the BSAS reflect theoretical behaviors and circumstances as a way to determine individuals' core beliefs (Montgomery et al., 1990).

The total score of the BSAS can range from 0-155 and is obtained by recoding and summing the items. Lower scores reflect a belief system that is suboptimal meaning that there is a lowered endorsement of an optimal belief system while higher scores indicate higher endorsement of optimal Africentric beliefs (Montgomery et al., 1990).

The BSAS is a useful clinical tool in psychotherapy as recognizing belief system of a client can be pivotal in the therapeutic process (Montgomery et al., 1990).

African Americans are not the only individuals that can endorse an Africentric worldview. The tenets of an Africentric belief system can be endorsed by all individuals and there is considerable value with validating the measure among subjects of all races (Montgomery et al., 1990). With that sated, the construct validity of the BSAS was determined on subjects ($n = 140$) from a sample of European American first-year college undergraduates at a private Midwestern university participating to satisfy course requirements. The study found that Cronbach's alpha of the scale ($n = 140$) was .80 and test-retest reliability ($n = 41$, one week apart) was .63 (Montgomery et al., 1990). There are no studies that used African Americans with this tool.

The total score from validation studies of the BSAS ($n = 95$) was found to have a significant correlation ($p<.001$) in the anticipated trend of all the benchmark variables: $r = +.50$ with the Social Interest Scale, and $r = -.51$ with the Dogmatism scale (Montgomery et al., 1990).

Data Analysis

For the purpose of this study, the data were screened and analyzed using version 21 of the Statistical Package for the Social Sciences (SPSS). To analyze the data, the paired samples *t* test was used to explore the means and to determine the impact of African-centered therapy on depression and Africentric worldview. Prior to analysis, assumption testing was conducted to ensure all paired *t* test criteria were met. No covariates were detected. The confidence level was set at 95%.

The research questions for this study were as follows:

Research Question 1: Will depressive symptoms decrease as a function of receiving African-centered therapy among African American adults?

*H*1A*:* Depressive symptoms will decrease after receiving African-centered therapy among African American adults.

*H*10*:* Depressive symptoms will not decrease after receiving African-centered therapy among African American adults.

Research Question 2: Will adherence to an Africentric worldview be affected after receiving African-centered therapy among African American adults?

*H*2A*:* Adherence to an Africentric worldview will increase after receiving African-centered therapy among African American adults.

*H*20*:* Adherence to an Africentric worldview will not increase after receiving African-centered therapy among African American adults.

Threats to Validity

One threat to external validity was the participant demographics. The researcher attempted to capture demographic characteristics that are representative of African-Americans on a broader scale including age, gender, educational level, employment status, and as a way to ensure that the study results could be generalized and replicated, but the data set prevented a sufficient representation.

On contrast, potential threats to internal validity included the variation of personal experiences occurring while engaged in treatment (Taylor & Asmundson, 2008). Such experiences could include differences in personal rapport with therapists, variances in receptiveness and understanding of African-centered therapy, exposure to life events that

may impact the effect of treatment, and attrition –the ability or willingness to participate in the primary study at the agency through its duration.

In this study, threats to construct validity included mono-method bias in which one instrument tool was used to measure each variable. As it relates to this research, depressive symptoms were measured using the SCL-90-R and Africentric worldview was measured using the BSAS. Another potential threat to construct validity is the interaction of different testing and treatments. The study participants may also be involved in another form of treatment outside of the agency such as medication treatment. Involvement in other treatments may have impacted participant scores.

Ethical and Research Procedures

For the purpose of this study, the Walden University Institutional Review Board (IRB) approval was obtained before accessing the archival data to ensure that the study was in aligned with research guidelines. Once IRB application was submitted and approved, the data was accessed by the researcher. The Walden IRB approval number was 01-15-16-0038436. The clinical director at the agency agreed to allow access to the data which was documented with the Walden Data Use Agreement. This study did not treat humans as archival data was used,

Additionally, there were no ethical or legal concerns related to data collection and analysis. Even though the researcher is an employee at the agency, she did not have any involvement in the data collection used in this study. The researcher did not work in the intake department that engaged participants in the study or in the outpatient department that conducted the therapeutic interventions with the participants.

Finally, no recruitment material was used for this study as archival data was used. The confidential data was secured on a password protected device that could only be accessed by the researcher. The dataset remained anonymous at all times. After the completion of the research project, the data was promptly deleted from the electronic file.

Summary

This quantitative study used archival data collect during 2012-2015 from a mental health agency in the Midwest to analyze the relationship between African-centered treatment and depressive symptoms and Africentric worldview. The agency utilizes the principles based on BSA to engage African American clients in treatment. The data accessed was part of a larger study at the agency and permission to use the data was obtained by the clinical director and approved by Walden IRB. Participants of the primary study were provided with consent forms before their voluntary participation. After IRB approval from Walden University, the specific data was analyzed included demographic information, SCL-90-R results, and BSAS results. For the purpose of this study, participant scores from the SCL-90-R (depressive subscale) were used to measure symptoms of depression and Africentric worldview was measured using the overall score of the BSAS. The scores to be analyzed were collected at the time of intake and after 1-year of receiving services during the participants' annual update. The data was analyzed using paired-samples *t* test in SPSS to determine the difference in means of the scores as indicated by the SCL-90-R and BSAS. The next chapter will describe the results of the analysis.

Chapter 4: Results

Introduction

The purpose of this study was to fill an identified gap in research on culturally relevant treatment modalities for African Americans. Specifically, this study explored the impact of African-centered therapy on depressive symptoms and Africentric worldview in African Americans.

BSA was the African-centered therapeutic modality explored in this research. The study was based on two research questions. The first research question explored if depressive symptoms would decrease as a function of receiving African-centered therapy. The second research question explored if adherence of an Africentric worldview is impacted after engaging in African-centered therapy. It was hypothesized that receiving African-centered therapy would decrease depressive symptoms and increase adherence to an Africentric worldview. This chapter will cover data collection methods, study results, and the data analysis findings.

Data Collection

This study used archival data from a mental health agency in the Midwest that provided African-centered treatment based on BSA. The data were collected from 2012-2015 and participants had the option of declining participation in the agency's larger study. The results reviewed for this research included the participants' demographic information, SCL-90-R results (depressive subscale), and BSAS scores. SCL-90-R and BSAS scores were analyzed before treatment and 1 year after treatment to determine the

impact of African-centered treatment on depressive symptoms and Africentric worldview.

The study consisted of 38 participants, aged 19-65. There were 31 female and 7 male participants. The majority were African American women. Of the participants, 28 (73.7%) identified as African American, two (5.3%) identified as White, five (13.2%) identified as biracial, and one (2.6%) identified as American Indian/Alaska Native. A significant proportion of the participants had a high school education 29 (76.3%). Three (7.9%) had a middle school education and four (10.5%) had an Associate's degree or higher. Ten (26.3%) of the participants were unemployed and disabled and 11 (28.9%) were employed. Students represented two (5.3%) of the participants and two (5.3%) were retired or a homemaker (see Table 1).

Table 1

Participant Demographics

Variable (*n* = 38)	*n*	%
Gender		
Female	31	81.6%
Male	7	18.4%
Race		
African American	28	73.7%
Bi-racial	5	13.2%
White	2	5.3%
American Indian/Alaska Native	1	2.6%
Missing	2	5.3%
Age		
19-29	9	23.6%
30-39	10	26.3%
40-49	9	23.6%
50-59	7	18.4%
60-65	2	5.2%
Missing	1	2.6%
Education		
Master's or Higher	1	2.6%
Bachelor's Degree	2	5.3%
Associate's Degree	1	2.6%
High School	29	76.3%
Middle School	3	7.9%
Missing	2	5.3%
Employment		
Employed	11	28.9%
Unemployed	1	2.6%
Disabled	9	23.7%
Student	2	5.3%
Retired/Homemaker	2	5.3%
Missing	13	34.2%

The SCL-90-R (depressive subscale) measures depressive symptoms. Before engaging in treatment, 20 (52.7%) of the participants reported minimal levels of depressive symptoms. After engaging in treatment, 15 (39.4%) of the participants reported minimal levels depressive symptoms. Prior to treatment, 10 (26.3%) reported moderate symptoms and one (2.6%) reported a severe elevation of depressive symptoms. After treatment, seven (18.4%) reported moderate symptoms and three (7.9%) reported a severe elevation of depressive symptoms (see Table 2).

Table 2

SCL-90-R Depressive Subscale—Descriptive Results

SCL-90-R Depression Subscale—Pretest		
n = 38	Frequency	Percentage
No Clinical Elevation	7	18.4%
Minimal Clinical Elevation	20	52.7%
Moderate Clinical Elevation	10	26.3%
Severe Elevation	1	2.6%

SCL-90-R Depression Subscale—Posttest		
n = 38	Frequency	Percentage
No Clinical Elevation	13	34.2%
Minimal Clinical Elevation	15	39.4%
Moderate Clinical Elevation	7	18.4%
Severe Elevation	3	7.9%

The BSAS measures adherence to Africentric worldview. Before engaging in treatment eight (21.1%) reported a moderately Africentric worldview; 25 (65.8%) reported a mixed mainstream worldview; and five (13.2%) reported a moderately non-Africentric worldview. After treatment, seven (18.4%) reported a moderately Africentric worldview; 26 (68.4%) reported a mixed mainstream worldview; and five (13.2%) reported a moderately non-Africentric worldview (see Table 3).

Table 3

Belief Systems Analysis Scale—Descriptive Results

BSAS Pre-test		
n = 38	Frequency	Percentage
Moderately Africentric	8	21.1%
Mixed Mainstream	25	65.7%
Moderately Non-Africentric	5	13.2%

BSAS Post-test		
n = 38	Frequency	Percentage
Moderately Africentric	7	18.4%
Mixed Mainstream	26	68.4%
Moderately Non-Africentric	5	13.2%

Results

Paired samples *t* test was used to examine differences the dependent variable means over an identified time frame. The time frame identified in this study in one- year post-treatment.

Research Question 1

The first research question asked would depressive symptoms decrease as a function of receiving African-centered therapy among African American adults. It was hypothesized that depressive symptoms would decrease after engaging in African-centered treatment. The null hypothesis stated that depressive symptoms would not decrease after engaging in African-centered treatment.

Table 4

SCL-90-R Means, (n = 38)

	M	*SD*	*SE*	95%CI
SCL-90-R pretest	3.97	1.53	.24	[3.46, 4.47]
SCL-90-R posttest	3.27	1.88	.30	[2.65, 3.88]

To test the hypothesis that depressive symptoms would decrease pretest (M = 3.97, SD = 1.53, N = 38) and posttest (M = 3.27, SD = 1.88, N = 38) a paired samples *t* test was conducted. Prior to data analysis, assumption testing was conducted and all assumptions were met. The results indicated a significant decrease in depressive symptoms pre-posttest, t (37) = .70, p = .017. The null hypothesis was rejected based on the results as $p < .05$.

Research Question 2

The second research question asked would adherence of an Africentric worldview be affected after receiving African-centered therapy among African American adults. It was hypothesized that adherence to an Africentric worldview would increase as a result of receiving African-centered treatment. The null hypothesis stated that adherence to an Africentric worldview would not increase as a result of receiving African-centered treatment.

Table 5

BSAS Means, (n = 38)

	M	*SD*	*SE*	95%CI
BSAS pretest	2.91	.58	.09	[2.72, 3.10]
BSAS posttest	2.91	.56	.09	[2.72, 3.09]

To test the hypothesis that Africentric worldview would increase pretest (M = 2.91, SD = .95, N = 38) and posttest (M = 2.91, SD = .92, N = 38) a paired samples t test was conducted. Prior to data analysis, assumption testing was conducted and all assumptions were met. The results indicated that there was not a significant increase in adherence to an Africentric worldview, t (37) = .002, p = .985. The results did not support the hypothesis and the null hypothesis was retained as $p > .05$.

Table 6

Paired Samples t-Test, (n = 38)

	M	*SD*	*p*	*t* (37)	95%CI	Cohen's *d*
SCL-90-R pre-post	.701	1.72	2.50	.017	[.13, 1.26]	.40
BSAS pre-post	.002	.64	.019	.985	[-.21, .21]	.003

In addition, a Pearson's *r* data analysis was conducted to determine if there were correlations between the pretest and posttest results of each variable. The Pearson's *r* analysis conducted for SCL-90-R and BSAS pretest results determined that there was not a significant correlation in the scores, $r = .208$, $p = .21$. Pretest results indicated that depressive symptoms and Africentric worldview were not correlated.

The Pearson's *r* analysis for SCL-90-R and BSAS posttest results indicated that there was a positive correlation between a reduction in depressive symptoms and an increase in adherence to Africentric worldview, $r = .01$, $p = .94$. Posttest results indicated that a decrease in depressive symptoms was related to an increase to adherence in Africentric worldview.

Table 7

SCL-90-R and BSAS Pre-Posttest Pearson's Correlations

	n	*r*	*p*
SCL-90-R/BSAS Pretest Correlation	38	.208	.21
SCL-90-R/BSAS Posttest Correlation	38	.01	.94

Summary

This chapter provided information on data collection, descriptive statistics, and presented the results from the data. The archival data was accessed from a mental health agency in the Midwest. Data from 38 participants were used and analyzed using paired samples *t* test in SPSS, Version 21 after obtaining IRB approval from Walden University.

The results from this study supported the hypothesis in research question one which stated that there would be a decrease in depressive symptoms pre-posttest. There was a statistically significant decrease in depressive symptoms as $p < .05$.

The null hypothesis for research question two was retained as there was not an increase in adherence to Africentric worldview after engaging in treatment. The results from the paired *t* test indicated that $p > .05$ and that there was not a statistically significant change in the means pre-posttest.

A Pearson's *t* test was conducted to determine if there was a correlation between the SCL-90-R and BSAS pretest and posttest results. The analysis found that there was not a significant correlation between the pretest results, but a positive correlation between SCL-90-R and BSAS posttest results.

Chapter 5 will provide information on the interpretations of the findings, on the limitations of the study, on recommendations for future research, and on the implications for positive social change.

Chapter 5: Discussion

Introduction

This purpose of this study was to determine the impact of African-centered treatment on depressive symptoms and Africentric worldview among African American adults.

Interpretation of the Findings

The results indicated (a) that a culturally relevant treatment modality could cause a statistically significant decrease in depressive symptoms and that there was a significant correlation between the SCL-90-R and BSAS posttest results but (b) that there was no statistically significant change in adherence to Africentric worldview.

Depressive Symptoms

The results for depressive symptoms supported the research hypothesis that African-centered treatment would decrease depressive symptoms. Thus the nontraditional treatment modality was successful in addressing the mental health needs of the study participants.

Despite the positive findings for the first research question, concerns regarding depression amongst participants and in the African American community remain regarding the ongoing experiences of oppression, racism, and marginalization amongst African Americans (Black, Gitlin, & Burke, 2011). Pretest results of the SCL-90-R indicated that 81% of the participants experienced elevated levels of depressive symptoms. Posttest results indicated that 65% of the participants had elevated levels of depressive symptoms. Understanding depression in African Americans means

understanding the impact that oppression has on the mental functioning of African Americans (Van Voorhis, 1998).

Oppression. As stated in previous research, oppression results in the marginalization of access to educational, financial, and judicial resources and can lead to psychological dysfunction (Van Voorhis, 1998). In this study, 83.6% of the participants had no more than a high school diploma and 28.9% were employed. Such statistics reflect the educational and financial marginalization of African Americans. Research on the relationship between oppression and depression by Hudson et al. (2012) found that household income and unemployment were high predictors of major depression.

Ethnic minorities, women, and individuals with employment limitations have increased likelihood of depression (Siddique et al., 2012). Previous research found that depressive symptoms were higher in participants living in impoverished neighborhoods. African Americans experience systemic oppression that may lead to a higher prevalence of depression due to ongoing exposure Carr et al., 2014; Cutrona et al., 2005).

Africentric Worldview

The results of this study did not support the hypothesis that adherence of an Africentric worldview would increase as a result of engaging in African-centered treatment. Such results reflect challenges that some African Americans may have with racial/cultural identity and accepting values of their own culture. Prior research stated that inequality and racial disparities may result in an individual having a low view of their self-worth, personal value, and self-esteem (Settles et al., 2010). In addition, an individual's view of themselves can also impact their overall worldview. The way that

African Americans identify themselves, hold personal judgements about being African American, and their perception of how society views African Americans can impact racial identity (Settles et al., 2010).

Issues with racial identity can result from internalized oppression stemming from ongoing systemic oppression. Oppression can create a barrier in an individual embracing their racial/cultural identity (Bulhan, 1985).

Prior research supports the challenges that participants in this study may have had in transitioning to a more Africentric worldview. As a result of attempting to assimilate into the dominant and oppressive culture, many African Americans have internalized a less than optimal worldview and reject positive beliefs about their own culture (Jackson & Sears, 1992).

Help-Seeking Behaviors

Peer reviewed literature also indicated that although African Americans have an increased susceptibility to mental illness, they tend to not seek mental health treatment and have increased pre-termination rates due to stigma (Breland-Noble, Bell, & Burris, 2011; Siddique et al., 2012; Sohail et al., 2014). The lack of openness to treatment is not evident in this research as each of the participants engaged in treatment for a least one-year. Such results reflect the willingness of African Americans to engage in treatment for extended periods of time.

Cultural Mistrust

Mistrust toward health research can be seen in the limited number of study participants for this study. Such mistrust has been deeply rooted for historical reasons and

some African Americans continue to fear being exploited and are uncertain about the research process even when provided with information about the purpose of the research (Brown & Moyer, 2010; Constatine et al., 2009). As evidenced by previous research, mistrust of the health system is reflected in the limited number of study participants as compared to the overall number of individuals serviced by the mental health agency from 2012-2015. The deeply embedded trust issues with the health system were reflected in the limited number of participants available for this study.

Limitations of the Study

A significant limitation in the study was the number of participants. The archival data available to the researcher was limited and did not result in a high number of participants. As experienced in this study, limitations of archival data include the lack of opportunity to follow-up with participants if additional information is needed (Johnston, 2014). Another limitation was the lack of comprehensive knowledge about what was actually captured in the data set. When the researcher is not involved in the data collection process, the researcher does not have awareness about issues including low-response rate (Johnston, 2014).

The benefit of using the limited data set in this study included the ability to access information that was relevant to the overall purpose of the study. Another benefit to using archival data is it provides researchers with an opportunity to analyze new frameworks and theories (Johnston, 2014). This benefit is useful in this study due to the lack of research on African-centered treatment modalities. It is not uncommon for studies testing new research theories to have a small number of subjects (Hacksaw, 2008).

Another limitation to this study is that the archival data was confined to a mental health agency in a lower-income neighborhood in the Midwest-thus limiting the ability to generalize the results to the demographics of the African American population in the United States. Lack of educational diversity is also a significant limitation to the generalizability of the results to the African American population as previously stated-83.6% of the participants had a high school diploma or lower and 28.9% were employed.

The therapists engaging clients in African-centered treatment trained and received ongoing training on how to engage the client in BSA. Another limitation to this research is not having knowledge that the individual therapists had a complete understanding of all aspects of BSA treatment delivery and adhered to the treatment principles.

Being unable to control for the personal experiences of the participants is another limitation to this study. Such personal experiences could subsequently impact the overall psychosocial functioning of participants.

The receptiveness/responsiveness of the client to this specific form of treatment presents another limitation to this research. As indicated, BSA has seven principles that is the core of service delivery (self-knowledge, spiritual development, intrinsic self-worth, extended self-identity, di-unital logic, and holistic worldview). Although all of the principles are interconnected, participants may not have been open to exploring one or more of principles used in the treatment approach, but the collected data is limited as it does not explore an individual's receptiveness/responsiveness to specific BSA principles.

Recommendations

Recommendations for ongoing research include a replication of this study using a larger sample size. The data limitation of this study prevented a diverse data set. Data with an increased sample size may allow for a more significant analysis when conducting a future study. Also, it is recommended that future research include a more in-depth analysis of the other SCL-90-R symptom subscales and the BSAS. Such research can provide a more comprehensive analysis on the impact of BSA and the impact that this treatment modality can have on the overall mental health functioning of individuals and not limited to only depressive symptoms.

It is also recommended that future research explore the worldviews of minority populations. Ethnic cultures tend to have worldviews that are different from mainstream society (Blume & Lovato, 2010). Such research can help gain greater insight on the relationship between worldview and mental health functioning of ethnic minorities.

The disparity in research on culturally relevant treatment modalities continues to be a relevant issue in the mental health field (Siddique et al., 2012; Sue, 2006). Such disparities have been recognized by government agencies. According to the Center for Disease Control (2015), there continues to be disparities in the overall health of ethnic minorities and there is an increased awareness in the need for culturally-relevant services. Another recommendation would be to openly explore other African-centered and culturally- relevant treatment modalities that could potentially have an impact the mental health of minority populations. Ongoing research to identify viable treatment modalities

can reduce disparities in research and mental health treatment delivery (Betancourt, 2006).

Implications

This researcher filled a gap research on the provision of an African-centered therapeutic treatment approach and provided information on other culturally relevant treatment approaches. The implication for social change can be found in the need for further research in treatment approaches that recognize and acknowledge cultural differences and how those differences can impact an individual's mental health and treatment outcomes.

In completing this study, the researcher contributed to addressing disparities in research involving African Americans and brings attention to the greater need to increase research on African Americans and other ethnic minorities. The researcher also contributed to the limited research on non-traditional theoretical frameworks and how such frameworks can lead to provisions in service delivery. Such research can positively contribute to the agenda of the American Psychological Association in the delivery of more culturally-competent services.

Summary

Depression is a prevalent issue in the African American community. African Americans have an increased likelihood of long durations of depression. Understanding the African American experience of functioning in an oppressive and marginalized society and how that impacts mental health functioning is a key component to understanding depression in African Americans. Although there is research that includes

African Americans, there continues to be a disparity in research on culturally relevant treatment provisions and outcomes for African Americans. Such research limitations contribute to increased health disparities in the provision of service delivery for African Americans.

This researcher provided information on a culturally relevant treatment approach as a way to contribute to fulfilling a gap in research. More specifically, this researcher studied the impact that receiving African-centered therapy had on depressive symptoms and adherence to Africentric worldview. The African-centered therapeutic approach used in the study was BSA and this holistic approach seeks to guide individuals to a more optimal or Africentric worldview. An individual's worldview is significant as it helps to shape an individual's behaviors and perceptions of their life experiences and can vary by culture. Adhering to an Africentric worldview can help reduce the impact of negative or stressful life experiences. More research is needed to expand knowledge on Africentric worldview.

Although there were limitations in the results of this research, this study contributed to social change by bringing awareness to depression in African-Americans, Africentric worldview, and African-centered treatment modalities. Culturally relevant treatment modalities continue to be a prevalent issue in the mental health system of care. Based on research and implications from this study, it is recommended that research continue to be expanded on non-traditional treatment modalities as a way to reduce treatment disparities among African Americans and other ethnic minorities.

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Appendix A: Walden Data Use Agreement

DATA USE AGREEMENT

This Data Use Agreement, effective as of 11/11/14, is entered into by and between LaRae Tillis and [redacted]. The purpose of this Agreement is to provide Data Recipient with access to a Limited Data Set ("LDS") for use in research **in accord with laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.** In the case of a discrepancy among laws, the agreement shall follow whichever law is more strict.

1. Definitions. Due to the study's affiliation with Laureate, a USA-based company, unless otherwise specified in this Agreement, all capitalized terms used in this Agreement not otherwise defined have the meaning established for purposes of the USA "HIPAA Regulations" and/or "FERPA Regulations" codified in the United States Code of Federal Regulations, as amended from time to time.

2. Preparation of the LDS. Data Provider shall prepare and furnish to Data Recipient a LDS in accord with any applicable laws and regulations of the governing bodies associated with the Data Provider, Data Recipient, and Data Recipient's educational program.

3. Data Fields in the LDS. **No direct identifiers such as names may be included in the Limited Data Set (LDS).** In preparing the LDS, Data Provider shall include the **data fields specified as follows**, which are the minimum necessary to accomplish the research: Demographic information, Belief Systems Analysis Scale scores, and Symptom Checklist-90-Revised (depression subscale) scores.

4. Responsibilities of Data Recipient. Data Recipient agrees to:

    a. Use or disclose the LDS only as permitted by this Agreement or as required by law;

    b. Use appropriate safeguards to prevent use or disclosure of the LDS other than as permitted by this Agreement or required by law;

    c. Report to Data Provider any use or disclosure of the LDS of which it becomes aware that is not permitted by this Agreement or required by law;

    d. Require any of its subcontractors or agents that receive or have access to the LDS to agree to the same restrictions and conditions on the use and/or disclosure of the LDS that apply to Data Recipient under this Agreement; and

    e. Not use the information in the LDS to identify or contact the individuals who are data subjects.

5. Permitted Uses and Disclosures of the LDS. Data Recipient may use and/or disclose the LDS **for its Research activities only.**

6. Term and Termination.

   a. Term. The term of this Agreement shall commence as of the Effective Date and shall continue for so long as Data Recipient retains the LDS, unless sooner terminated as set forth in this Agreement.

   b. Termination by Data Recipient. Data Recipient may terminate this agreement at any time by notifying the Data Provider and returning or destroying the LDS.

   c. Termination by Data Provider. Data Provider may terminate this agreement at any time by providing thirty (30) days prior written notice to Data Recipient.

   d. For Breach. Data Provider shall provide written notice to Data Recipient within ten (10) days of any determination that Data Recipient has breached a material term of this Agreement. Data Provider shall afford Data Recipient an opportunity to cure said alleged material breach upon mutually agreeable terms. Failure to agree on mutually agreeable terms for cure within thirty (30) days shall be grounds for the immediate termination of this Agreement by Data Provider.

   e. Effect of Termination. Sections 1, 4, 5, 6(e) and 7 of this Agreement shall survive any termination of this Agreement under subsections c or d.

7. Miscellaneous.

   a. Change in Law. The parties agree to negotiate in good faith to amend this Agreement to comport with changes in federal law that materially alter either or both parties' obligations under this Agreement. Provided however, that if the parties are unable to agree to mutually acceptable amendment(s) by the compliance date of the change in applicable law or regulations, either Party may terminate this Agreement as provided in section 6.

   b. Construction of Terms. The terms of this Agreement shall be construed to give effect to applicable federal interpretative guidance regarding the HIPAA Regulations.

   c. No Third Party Beneficiaries. Nothing in this Agreement shall confer upon any person other than the parties and their respective successors or assigns, any rights, remedies, obligations, or liabilities whatsoever.

   d. Counterparts. This Agreement may be executed in one or more counterparts, each of which shall be deemed an original, but all of which together shall constitute one and the same instrument.

e. Headings. The headings and other captions in this Agreement are for convenience and reference only and shall not be used in interpreting, construing or enforcing any of the provisions of this Agreement.

IN WITNESS WHEREOF, each of the undersigned has caused this Agreement to be duly executed in its name and on its behalf.

DATA PROVIDER	DATA RECIPIENT
Signed:	Signed: LaRae Tillis
Print Name:	Print Name: LaRae Tillis
Print Title: Clinical Director	Print Title: MA, LSW - Walden Student

Appendix B: Symptom Checklist-90-Revised (Depression Subscale Items)

5. Loss of sexual interest or pleasure.

14. Feeling low in energy or slowed down.

15. Thoughts of ending your life.

20. Crying easily.

22. Feelings of being trapped or caught.

26. Blaming yourself for things.

29. Feeling lonely.

30. Feeling blue.

31. Worrying too much about things.

32. Feeling no interest in things.

54. Feeling hopeless about the future.

71. Feeling everything is an effort.

79. Feelings of worthlessness.

Appendix C: Belief Systems Analysis Scale

1. The more important consideration when looking for a job is not the money offered, but the people I will be working with. (*p*) (1, 4, 10)

2. English should be the only national language. If one wants to live in this country, one should learn to speak the language; bilingualism is unimportant. (*n*) (6, 8)

3. If I could make a choice, I would prefer to lead a wealthy, exciting life as opposed to one that is peaceful and productive in terms of helping other people. (*n*) (1, 2, 4)

4. In order to know what's really going on you need to look at the scientific data rather than the individual's personal experience. (*n*) (5, 9)

5. Working at a job with meaning and purpose is more important than the money received from a job. (*p*) (1, 2, 10)

6. Winning the lottery would solve all of my problems. (*n*) (1, 2, 3, 10)

7. This country would be better off if we restricted immigration to a very select few. (*n*) (4, 8)

8. Welfare is a mistake: individuals must learn to help themselves. (*n*) (4)

9. When I meet acquaintances on the street, I note the type of clothes they are wearing and compare them to mine. (*n*) (1, 10)

10. Race or nationality reveals more about an individual than he/she may realize. (*n*) (6, 10)

11. More than anything else, I am most convinced by another's opinion if he/she has the

statistics to back it up. (*n*) (5, 9)

12. When I encounter new acquaintances at meetings or work-related activities, I note the type of clothes they are wearing and am impressed if they are “dressed for success.” (*n*) (1, 10)

13. When someone challenges my beliefs, I am eager to set him/her straight. (*n*) (3)

14. Pain is the opposite of love: In other words, an act of love cannot cause pain. (*n*) (7)

15. If a “friend” were to betray my confidence and tell some other people a secret of mine, the best way for him/her to learn a lesson is for me to do the same thing to him/her when I get a chance. (*n*) (3, 4)

16. If my opinion of my uncle has always been different than everyone else’s, then I must be perceiving him wrong. (*n*) (7)

17. It is easy for me to see how the entire human race is really part of my extended family. (*p*) (8)

18. When considering all the difficulties of life, I have trouble seeing any meaning or order to it. (n) (7)

19. I find myself worrying a lot about circumstances in my life. (n) (1, 10)

20. If I just had more money, my life would be more satisfying. (n) (1, 2, 10)

21. If I were better looking, my relationships with others would be more satisfying. (n) (1, 10)

22. I feel badly when I see friends from high school who now have better cars, clothes, or homes than I do. (n) (1, 10)

23. Sometimes when I am good and do my best, I still suffer; this is an indication that good does not necessarily triumph over evil. (n) (7)

24. Although I have a favorite kind of music I listen to, I can usually get into and enjoy most kinds of music. (p) (3, 6)

25. When I am confused or unclear about myself or the world about me, I try to push these concerns out of my mind and go on with my life as usual. (n) (7)

26. Past philosophers like St. Augustine and Descartes are less relevant today than they were 100 years ago before the modern age. (n) (6)

27. Despite my religious preference (e.g., Jewish, Muslim, Catholic, etc.), I still believe there are teachings from different religions that are valid. (p) (6)

28. I am uneasy and bothered by my responsibilities at work and at home. (n) (2, 3, 4)

29. I can remain calm and peaceful even when my boss blames me for another's mistakes. (p) (1, 3)

30. If I were president, I would invest more money to develop social programs and less money in high tech development. (p) (4, 8)

31. There are some people in my past whom I believe I should never forgive. (n) (3)

Notes. p = positively keyed in the Afrocentric direction; *n* = negatively keyed in the Afrocentric direction.

Factor 1: Interpersonal Valuing; Factor 2: De-emphasis on Appearance; Factor 3: Integration of Opposites; Factor 4: Nonmaterial-Based Satisfaction; Factor 5: Optimism.

Numbers in parentheses reflect an Afrocentric construct item that was designed to assess (1) Reality is known in a sensory (material) and extrasensory (spiritual) fashion; (2) Value on interpersonal relationships; (3) Value on harmony; (4) Value on communalism; (5) Value on experiential knowledge; (6) Holistic world view; (7) Di-unital logic (objects can be alike and different at the same time); (8) Extended self-identity; (9) Knowledge gained through inductive synthesis and self-awareness; (10) Sense of worth is intrinsic in being.