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Uniting African Philosophy with Traditional African Dance Rituals to Help Heal Mental Health Symptoms from the Impact of the African Diaspora

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CERTIFICATE OF APPROVAL

Clinical Research Project

This is to certify that the Clinical Research Project of

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Abstract

The mental health challenges of members of the African diaspora have been a worldwide occurrence for centuries, initially beginning with the transatlantic slave trade. Africans were scattered abroad to different countries and subjected to the severe psychological impact of enslavement. Despite the considerable financial systemic pressure of profit in the slave trade, it caused significant harm to the enslaved Africans and their descendants by erasing Africa's memory and their healing traditions from the hearts and minds of the population. Severe mental health symptoms can arise from oppression and the impact of the African diaspora. This dispersion has left many African Americans with a lack of cultural identity, depression, substance use, anxiety, and posttraumatic stress disorder (Monteiro & Wall, 2011). African descendants from many backgrounds have few cultural-related treatments. This paper explored the mental health consequences that have resulted from the impact of the African diaspora. It reviewed and discussed the literature on Afrocentric Kawaida principles and African dance rituals related to the process of healing and its applicability to people of color. It provided examples of African healing dance practices as a therapeutic aspect of the historical roots in north Africa. The author proposed the potential utility of using Afrocentric dance interventions with an African philosophy-centered framework and examined the concepts that are culturally relevant to aid people of color subjected to oppression from the African diaspora.

UNITING AFRICAN PHILOSOPHY WITH TRADITIONAL AFRICAN DANCE RITUALS TO HELP HEAL MENTAL HEALTH SYMPTOMS FROM THE IMPACT OF THE AFRICAN DIASPORA

DEDICATION

I dedicate my Clinical Research Project work to my family and many friends. A special feeling of gratitude to my Grandmother Dorothy Jones and mother Juvanva Battle whose words of encouragement and push for tenacity in my ears and in my heart. My sisters Kourtnea and Princess and Uncle Richard have never left my side and are very special to me.

I also dedicate this Clinical Research Project to my many friends, peers and professors who have supported me through the process. I will always appreciate all they have done, especially Dr. Gary Howell and Dr. Patricia Dixon for helping to master my skills and the many hours of support they have provided me through the years.

I dedicate this work and give special thanks to my best friend Neasha Powell and all my nieces and nephews for being there for me throughout the entire doctorate program.

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CHAPTER I: INTRODUCTION

African Americans and others influenced by the African diaspora have limited to nonexistent culturally relevant interventions and treatments. The African diaspora refers to the mass displacement of African people during the transatlantic slave trade. Although there has been some progress made since slavery, mental health and medical disparities persist within minoritized populations, especially among people of color. Suicidal ideation in non-Hispanic Black students from grades 9–12 who attempted suicide was 8.5% males compared to non-Hispanic Whites (6.4%), and 15.2% non-Hispanic Black women compared to non-Hispanic White women (9.4%; Centers for Disease Control and Prevention [CDC], 2022). According to the most recent data of the Substance Abuse and Mental Health Services Administration (SAMHSA, 2020), the percentage of non-Hispanic Blacks who received mental health services in 2019 was 9.8% compared to 19.8% of non-Hispanic Whites (SAMHSA, 2020). The percentages of reasons listed for not using mental health services among Black or African Americans from 2015-2019 is cost of insurance (41.0%), low perceived need (24.9%), stigma (34.1%), structural barriers (37.5%), and did not think treatment would help (7.6%; SAMHSA, 2020). These percentages not only justify the need for African Americans with low-cost access to healthcare, but a necessity to include culturally competent clinicians, and introduce a theoretical framework of African culture principles with African dance rituals to help create lower mental health issues, psychological flexibility, and empower the building blocks of self-awareness.

The historical significance of the African diaspora was termed initially in the 1950s, which brought millions of Africans to the New World. It has had a significant psychological impact and left ethnic minorities with an unprecedented, unequal sense of self and culture with

experiences of doubt about who they are, where they are, and general discomfort about where they have come from. The psychological effects of the African diaspora play a vital role in physical and mental health today (Williams-Washington, 2010). The journey of bondage and mass dispersion of Africans during the Transatlantic slave trades from Africa to the United States and the Caribbean influenced the source of historical trauma. Historical trauma is defined as psychological and emotional damage that occurs throughout the lifespan and across generations (Williams-Washington, 2010).

Slavery disrupted the African culture creating a perpetuating devasting effect on social changes, racism, prejudice, discrimination, and oppression. Notably, the history of oppression passed down from generations in the Black community can result in health disparities, domestic violence, substance use, mood, and trauma-related psychological problems. Although slavery ended in 1865, the resulting psychological susceptibility, emotional distress, and cognitive strain created a pattern in the experience of many African Americans. Following the displacement during the African diaspora, African Americans continue to encounter immeasurable historical trauma from race-related events—namely, the Rosewood Massacre of 1923, the Tuskegee Syphilis Experiment from 1932 to 1972, the Los Angeles riot in 1992, and the recent injustices of police brutality at alarming rates.

Mass incarceration is one example of the disparities among Black people who are imprisoned the United States. The staggering rise of the prison population struck the minority communities the hardest. Blankenship et al. (2018) found that across the different age groups, Black males are incarcerated six times more than White males. Higher rates of incarceration can impact education, employment, intimate relationships, and health such as infant mortality, more associated within the Black community (Blankenship et al., 2018).

Police brutality continues to highlight the tenuous racial relationship between American law enforcement and African Americans. Racial trauma appears within the experiences of racial bias, ethnic discrimination, and racist encounters that can cause lasting mental and emotional harm. The startling increase of known video-taped fatal incidents among Black individuals from youth to adulthood has continued to present a lack of trust within American law enforcement in the Black community. DeGruy (2017) discussed a 2014 article that investigated the view of Black boys in the regard of childhood innocence, and whether young Black boys are perceived as equal to their peers within other races. The article concluded that Black boys are viewed as being older and showing less innocence in the view of their childhood compared to their White peers of the same age group (Goff, 2014). Two years before this article was published, Travon Martin, an unarmed 17-year-old Black male, was shot by a neighborhood watch official who claimed self-defense. Since this tragic incident, there are still countless killings of unarmed Black people by law enforcement. Racial trauma involves all acts of racially motivated crimes, such as the recent attack in Buffalo, NY, where 10 people were killed while the attack was livestreamed online. Dr. Frank Worrell, president of the American Psychological Association, cited that "violence rooted in racism and hate has become too common in our society." Dr. Worrell also reported the effects of racial trauma can lead to increase rates of depression, anxiety, stress, PTSD, and substance use disorders (APA, 2022). The COVID-19 pandemic is yet another concern with a disproportional impact on African Americans. The slight progress of closing the gap for people of color within the medical community took a massive setback during the COVID-19 pandemic. The challenges affecting racial and minority groups include education, income, employment access, racism/discrimination, healthcare access, transportation, rural communities, and distrust within the medical community (CDC, 2022). Black Americans make up 33% of the deaths reported

from COVID-19 (Liu & Modir, 2020). This reflects a continuation of the historical pattern of the discrimination against minority groups.

Cultural trauma experiences (individual, group, or mass trauma), substance use disorders and PTSD are interconnected issues. Intergenerational trauma can produce disconcerted, disconnected distress for the generational survivors. This state of pain can lead to a range of negative outcomes, such as substance use. Alcohol and drug use, for example, frequently serve as a coping mechanism for some individuals to manage traumatic stress and PTSD symptoms (SAMSHA, 2014). Farahmand (2020) highlighted how systemic racism contributed to the development of racial disparities seen among substance use disorders.

Dance Movement Therapy (DMT)

The concept of DMT is an additional culturally holistic way to use movement to promote emotional, social, and physical integration (Leseho & Maxwell, 2010). It helps to provide emotional relief. Some psychotherapy approaches in Africa use group activities such as "suycahs," singing, dancing, and prayers to express themselves. The use of DMT is a new and evolving psychotherapeutic intervention that is applicable to other Afrocentric interventions for establishing a theoretical framework for a culturally diverse population while improving health and well-being. The use of dance in psychotherapy integrates physical and artistic expression and communication in a body-orientated way.

The expression of emotions through dance connects directly to the spiritual awareness in African ritual dances and ceremonies. Members of the African diaspora have a strong religious connection. They have developed their theoretical framework of spiritual transformation. Traditional African dance rituals are connected throughout Central and South Africa. Dance and spirituality are integrated with rituals and ceremonies that address complex issues through

rhythms and music within a social context (Vinesett et al., 2015). The inclusion of dance and movement within the medical field has continued to generate a buzz in the nontraditional therapy world. Currently, dance and movement approaches have been shown to help with physical conditions and decrease the neurological decline of brain functioning (Liu et al., 2021).

One core belief of members of the African diaspora is that the mind and body are one and must be integrated completely to help heal, transform, and inspire. Similarly, DMT with the American Dance Therapy Association (ADTA) incorporated an organization to connect and create a bond for Africans, African Americans, Afro-Caribbean's, Afro-Latinxs descent, and other people of color from the African diaspora (ADTA, 2018). The Black Moving Affinity Group in Community (Black MAGIC) recognized the significance of bridging the connection between therapeutic approaches to mental health and aligning a space for healing with dance in the African communities.

Kawaida is the African-related philosophy developed by Dr. Maulana Karenga, who created a set of principles called Nguzo Saba. Dr. Karenga established a program that would help inspire, satisfy human needs, and transform people in the process (Kalonji, 2014). His principles provide members of the African diaspora a way to become self-conscious of their own life. Dr. Karenga's purpose was to create a transformative practice that would help bring together Black communities and gain the highest sense of self-awareness and values. The central tenet in Kawaida is the fundamental knowledge of culture (Karenga, 1996). To understand one's culture is to understand one's identity, purpose, and direction. One of the seven core areas of culture is creative production. Creative production integrates aspects of music, literature, and dance.

The Nguzo Saba consists of seven value principles of the highest standard that promote, encourage, and develop a cohesive sustaining community and personal excellence. These principles are *umoja* (unity), *kujichagulia* (self-determination), *ujima* (collective work and responsibility), *ujamaa* (cooperative economics), *nia* (purpose), *kuumba* (creativity), and *imani* (faith; Kalonji, 2014). The current researcher's proposed model based on these tenets is outlined in Chapter V.

Statement of the Problem

Historically, African Americans and other people of color have suffered inequality from mental health disparities. Mental health disparities within diverse communities are the result of many factors, including the inaccessibility of specific and general health care, cultural stigma, lack of awareness with limited psychoeducation of mental health treatment, and discrimination. The United States is making some progress—however slow—to mitigate such disparities. A statement from the White House identified how the Biden-Harris administration is advancing health equity among Black people within the country (U.S. Office of the Press Secretary, 2022).

The released statement indicated that 76% of uninsured African Americans are able to find a healthcare plan for less than $50 a month. Mortality rates are also disproportionately higher among Black families. The implementation of implicit bias training with all healthcare providers could reduce some racial disparities (U.S. Office of the Press Secretary, 2022). Ward and Brown (2016) explained why African Americans have lower use of mental health services. Many do not seek treatment due to stigma in the community, poor quality of mental health care, and non-culturally-specific treatments and interventions (Ward & Brown, 2016). For many African Americans, their experience has been subjected to sustained violence and trauma, especially in the United States, more than their White counterparts. The consequences of mental

illness in minorities are often more pervasive and longer-lasting compared to Whites, with significant unmet needs for mental health care. Previous scholars have shown that current Western psychotherapy evidence-based treatments do not always meet the needs of minoritized populations.

Due to medical disparities and historically disadvantaged racial and ethnic groups, culturally adapted mental health interventions are a pressing necessity. This topic remains an under-researched area of concern. Advocacy for mental health treatments modified to a client's cultural context can improve their overall well-being and quality of life. According to *Healthy People 2020*, race and ethnicity factors have continued to shape a person's ability to achieve adequate health care (HealthyPeople.gov, 2020). Compared to White people, people of color typically receive a far lower quality of health care and have less access to care. One interpretation of this medical disparity is linked to the prevalence of African Americans having limited access to affordable health coverage or having public health insurance versus private coverage for White people (Lee et al., 2021). To illustrate, challenges during the pandemic of limited income, unemployment, and decreased medical visits have resulted in a mortality rate of 97.9 out of every 100,000 African Americans who died of COVID-19, which is double that of White people, at 46.6 per 100,000 (Reyes, 2020).

In addition to mental health disparities, the Black community continues to experience microaggressions, hate crimes, and physical assault. Microaggressions is a term for daily or common unintentional or intentional racial slights, bias language, and negative insults to people of color (Sue et al., 2009). The discussion of microaggressions has gained much attention due to how racial microaggressions can impair relationships within the mental health system. According to the most recent APA statistics, 84% of psychologists are White, 6% are Hispanic, 4% are

Black/African American, 4% are Asian, and 2% are American Indian/Alaska Native or Native Hawaiian/Pacific Islander (APA, 2020). These findings show more than demographics within the field of psychology, these statistics also gives an indication of the high possibility of racial microaggressions and biases within this field towards minorities based on prior cultural conditioning (Sue et al., 2009). As mentioned later within this study, the authors of several articles have described the need for therapists to become aware of their biases and stereotypes; when they fail to do so, the delivery of a therapeutic relationship lacks providing quality care to people of color and can be associated with negative physical and emotional outcomes and termination of therapy (Chae et al., 2011; Hook et al., 2017; Sue et al., 2009).

Hate crimes are very prevalent within the United States. In 2020, 61.8% of bias motivation for victims of single-bias incidents in 2020 consists of race, ethnicity, and ancestry (U.S. Department of Justice, 2020). Hate crimes can be categorized as an offense of violent acts or threats motivated towards an individual, group or property based on race, religion, sexual orientation, gender identity, ethnicity, color, or disability (Bureau of Justice Statistics, 2022). Out of a total of 66,642 people affected by hate crimes within the last 10 years, 38,625 were threats and acts based on race and ethnicity, and the highest race/ethnicity affected were 20,084 African Americans (Federal Bureau of Investigation, 2020). Curtis et al. (2021) indicated that the publicized view of hate crimes against Black people results in poorer mental health; therefore, their results suggest that by decreasing racism, racial violence and hate crimes, there is a strong likelihood of decreasing the negative mental health symptoms of African Americans (Williams-Washington, 2010).

Hate crimes can include acts of physical assault or the threat of an attack towards someone (APA, 2020). Physical assault along with physical abuse can cause detrimental serious

harm. Unfortunately, African Americans continue to experience physical assault from police brutality. Police brutality can be defined as the dehumanizing intent to threaten, intimidate, and cause physical assault and abuse (Alang et al., 2017). Even more, individuals who experience physical assault are at risk for developing mental health conditions (Alang et al., 2017). Prior researchers have supported that police brutality can be a social determinant of health and can affect health and interpersonal relationships with higher levels of morbidity and mortality in the Black community (Alang et al., 2017).

Purpose of the Study

To explore and develop an Afrocentric value orientation to help with psychological flexibility and stability from intergenerational trauma, the current researcher developed a holistic, culturally-based concept of dance therapy and culturally centered principles. The goal was to discuss the limited research and develop a culturally adapted treatment specifically for people in the African diaspora. This adapted treatment can decrease the lasting effects of intergenerational trauma and serve as a guide for improving self-belongingness, overall well-being, and sense of freedom and psychological stability.

During the displacement of African people, ships traveling the Middle Passage transported approximately 472,000 captured Africans to the United States, of which approximately 388,000 survived the journey (Graff, 2017). All of these survivors experienced psychological trauma beyond any imaginable experience in this voyage. According to Gump (2011), the psychological narrative of slavery includes the involuntary capture of Africans induced disruption of their land, ancestors, and customs. All identity of African culture and their place in the world was stripped away and destroyed. The physical, emotional, and verbal abuse

of adults and children that existed from the period of slavery resulted in intergenerational trauma that is still present within the African American community.

The predisposing factor of cultural trauma increases the psychological adversities of Black people. Sternthal et al. (2011) highlighted that African Americans show higher stress levels within several life domains. Increased stress from a psychological level can predict depression, poor health, limited physical abilities, and chronic illness. In another study by Rahn et al. (2019), the authors examined how the chronicity of depression among African Americans is 56% higher than in Caucasian patients. Rahn et al. also reported that only half of African Americans seek treatment compared to Caucasians, and they have more severe and disabling symptoms. Although there is evidence that African Americans have lower rates of depression symptoms compared to non-Hispanic Caucasians, scholars have agreed that this resilient nature is also due to many individuals being misdiagnosed.

Research Questions

This clinical research projec focused on the mental health disparities among minorities, specifically the members of the African diaspora. The researcher sought to answer the following research questions:

1. What are the primary interventions used in treating trauma, depression, and anxiety?
2. How are culturally specific interventions used in treating trauma, depression, and anxiety in Black people?
3. What types of Afrocentric dance intervention approaches could help with trauma, depression, and anxiety in Black people?

Research Procedure

A review of the primary interventions used in treating individuals suffering from trauma, depression, and anxiety was conducted to inform this investigation. In the chapters to follow, the findings of the researcher's review of how culturally specific interventions are used in treating trauma, depression, and anxiety, which is applicable to Black people are presented. Lastly, the varied types of Afrocentric dance interventions and approaches that can help with trauma, depression, and anxiety in Black people are discussed. The sections of the literature review reflect the primary interventions used for trauma, depression, and anxiety. The current variables of evidenced-based interventions of trauma, depression, and anxiety were analyzed. The search for relevant articles and books was conducted using the following databases: APA PsycArticles, APA PsycBooks, APA PsycINFO from EBSCO and ScienceDirect journals. The search terms used included: *anxiety, benzodiazepines, CBT, cognitive behavioral therapy, CPT, cognitive processing therapy, depression, EMDR, EMDR therapy, eye movement desensitization and reprocessing evidenced-based practices, generalized anxiety disorders, MBCT, mindfulness-based cognitive therapy, music therapy, PE, prolonged exposure, PTSD, posttraumatic stress disorder, psychotropic medications, trauma, RCT, randomized clinical trial, and randomized controlled trial, SSRIs,* and *selective serotonin reuptake inhibitors.* The search parameters limited the results to materials published between 1987 through 2022.

CHAPTER II: CURRENT APPROACHES TO TREATMENT

The American Psychological Association (2022) developed a clinical practice guideline for the primary treatment of posttraumatic stress disorder in adults with cognitive processing therapy (CPT), trauma-focused cognitive behavioral therapy (TF-CBT) with emotional processing theory (EPT), social cognitive theory (SCT), cognitive behavioral therapy (CBT), and prolonged exposure therapy (PE). In addition, the APA panel recommended additional interventions such as brief eclectic psychotherapy (BEP), eye movement desensitization and reprocessing (EMDR), and narrative exposure therapy (NET). Considering the focus on the primary trauma interventions, this study will explore the interventions of CPT, TF-CBT (EPT & SPT), CBT, and PE.

Trauma Treatment

Cognitive Processing Therapy

This therapeutic approach is one of the recommended psychotherapies that has the most robust evidence for the efficacy of reducing posttraumatic stress symptoms. CPT uses a specific type of cognitive behavioral therapy that helps reduce the symptoms of various traumatic events such as child abuse, combat, sexual assault, and natural disasters. CPT is evidence-based and is widely used within the Veteran Affairs Healthcare System. Manualized CPT is delivered over twelve 60- to 90-minute sessions once or twice per week and helps clients modify maladaptive cognitions that developed following the traumatic incident (APA, 2017).

Regarding traumatic experiences, survivors try to cope and understand what happened, which can lead to distorted and faulty cognitions. CPT assumes that people assimilate, accommodate, or over-accommodate. Assimilation is defined when new incoming information is modified to resemble one's prior beliefs. Accommodation is when one's prior belief is adapted to

the new incoming information. Over-accommodation is when one specifically changes their prior beliefs to prevent future trauma experiences. The goal of CPT is to help the client develop accommodation (Watkins et al., 2018).

CPT was first developed to treat the survivors of sexual assault victims. The development of CPT was to create an intervention similar to exposure therapy by activating the distressing memory and identifying the conflicts of faulty beliefs associated with the memory (Resick & Schnicke, 1992). CPT is distinguished from CBT by (a) identifying and modifying the interpretation of the event rather than the event itself and (b) allowing the client to process and feel the emotions of their beliefs within a safe environment (Resick & Schnicke, 1992). In the study of Resick and Schnicke, the investigators examined how CPT can result in clinically significant improvement with PTSD and depressive symptoms that is maintained over a 6-month period.

There is strong empirical data that support the use of CPT within a variety of populations. PTSD with co-occurring depression is just one of the options proposed for CPT treatment. The historical research of CPT identified the approaches of core skill, and narrative written trauma experiences (Lenz et al., 2014). Lenz et al. conducted a meta-analysis of the effectiveness of cognitive processing therapy, and determined their results provided evidence of the support of CPT for the treatment of PTSD. The limitation within this article suggests CPT may be the most relevant for Caucasian clients (Lenz et al., 2014).

More specifically, CPT assists the client in creating a new understanding of their "stuck points" and conceptualization of their traumatic event, fostering a reduction in the adverse effects it may have on their life (Resick et al., 2003). The recommendation of CPT by APA emphasizes that the effects of CPT, shows insufficient or low strength of causing severe harm (APA, 2017).

After a thorough exploration of CPT, the evidenced-based approach is one of the leading interventions to help reduce PTSD symptoms with co-morbid depression symptoms. In determining the outcome measures of CPT's effectiveness, participants within the research studies met the inclusion criteria of a PTSD diagnosis. The overall goals of using CPT for PTSD are to (a) identify and address unhelpful beliefs related to the traumatic event, (b) process the emotions and strong feelings attached to the memory, and (c) develop accommodation by modifying and challenging the unhelpful beliefs to gain a new understanding to help reduce the negative effects that impact areas of life (Watkins et al., 2018). One common factor within the substantial clinical trials is the lack of generalizability involving predominately White male participants. Najavits (2015) reported that African Americans were significantly less likely to complete CPT as compared to Caucasians (45% vs 73%). Currently, intergenerational trauma, racial trauma, and the negative impact of oppression is not captured within the posttraumatic stress disorder criteria in the *DSM-5* (American Psychiatric Association, 2017).

African Americans are continuing to experience discrimination and oppression which attributes to the high psychological distress within this community (Chae et al., 2011). The lack of research and clinical trials with racial trauma of oppression of African Americans with evidenced-based psychotherapies indicates the need to develop specific cultural adaptation interventions of CPT. According to Najavits (2015), the manualized structure within CPT has an average of 28% dropout rate to include African Americans were significantly less likely to complete CPT when compared with Caucasians (45% versus 73%). The predictors of high dropout rates which includes more pretreatment avoidance, reexperiencing, more anger and impairments within social functioning (Alpert et al., 2020). Due to the reports of CPT high

dropout rates and less completion of treatment for African Americans, it is evident that CPT may not be the best intervention for members of the African diaspora.

Cognitive Behavioral Therapy

The development of CBT is based on the cognitive model where thoughts may influence emotions, mood, and behavior (Beck, 2011). CBT helps clients to identify maladaptive (i.e., negative) thoughts and behaviors and challenge them. In modifying and challenging these thoughts and behaviors the goal is to develop alternative ways of thinking and acting to produce less psychological or physical distress (Beck, 2011). Ten basic principles are the main tenets within CBT. The principles consist of understanding a continuous conceptualization of clients problems, building a trusting and therapeutic relationship, a collaborative effort between client and therapist, goal-directed sessions with a focus on specific tasks, maintaining and modeling being present-focused, providing psycho-education and teaching cognitive concepts, establishing an achievable timeframe for goal completion, maintaining structure within sessions, teaching and allowing clients to practice identifying and responding to their maladaptive thoughts and behavior, and integrating other intervention techniques that would benefit a specific client (Beck, 2011).

Several therapies have developed from Beck's cognitive behavior therapy. Although other cognitive interventions have the same core model of CBT, the techniques may vary with cognitive and behavioral management. CBT is based on therapists developing a strong therapeutic alliance and engaging with the client on a deeper level, to identify their beliefs about how they see themselves, their world, and others. CBT and CPT present similar techniques; however, CBT focuses on present problems, and CPT focus on past traumatic experiences. CBT

can be adaptable and has been shown to be effective with children, adolescents, and adults (Beck, 2011; Halder & Mahato, 2019).

The central feature within CBT are take-home homework assignments that help to serve increase practice and understanding of the materials within each session (Beck, 2011; Conklin et al., 2018). The APA guideline panel for the Treatment of PTSD in adults recognized CBT as an effective treatment in PTSD due to the cognitive distortions that are associated with PTSD (APA, 2011). Kar (2011) conducted a review in the effectiveness of CBT for various types of traumas in PTSD. The results showed individuals who are at risk for PTSD, and receive CBT within a month of the event, can have lasting benefits (Kar, 2011). As mentioned previously with CPT, PTSD can encompass a substantial amount of different trauma experiences. Prior studies of CBT, shows effective results in decreasing PTSD symptoms (Dorrepaal et al., 2013; Kar, 2011) and harm reduction (APA, 2017); however, compelling evidence challenges the generalizability of CBT treatment for diverse populations, substance abuse, and complex trauma (Dorrepaal et al., 2013).

CBT interventions can be widely used for both individual and group therapy. CBT groups help foster the emotional support with common experiences among group members (Sloan et al., 2012). The common interpersonal symptoms within PTSD include isolation, withdrawal, and lack of trust with others, CBT groups provide a safe community for openness and processing emotional experiences (Sloan et al., 2012). Watkins et al. (2018) reported that cognitive reconstructing and exposure techniques effectively decrease PTSD symptoms. CBT individual and group formats have 12-16 sessions which includes skill training and focuses on the present versus past events (Sloan et al., 2012). Although promising clinical trials have determined the efficacy of CBT for PTSD symptoms, the cognitive restructuring of beliefs may not be

advantageous for member of the African diaspora due to the cultural mistrust this community has faced due to discrimination and invalidation.

Trauma-Focused CBT

The trauma-focused approach by Judith Cohen, Esther Deblinger, and Anthon Mannarino treated children who experienced early trauma and abuse. In integrating the theory of how early trauma and abuse can eventually lead to self-harm, aggressive behaviors problems, and robust mental health concerns such as depression and anxiety, trauma focused CBT (TF-CBT) was created. Emotional processing theory (EPT) and social cognitive theory (SCT) are two other theories used to explain how CBT is effective for trauma. Emotional processing theory is a treatment within CBT that focuses on processing the emotional responses to traumatic experiences. Alpert et al. (2020) posited that trauma and anxiety-related conditions can stem from various networks within our stimuli response system. Individuals can experience cognitive, emotional, behavioral, and physiological reactions towards incoming networks of stimuli. EPT is effective in trauma-focused cognitive behavioral therapy for children and adolescents. For example, EPT develops a trauma narrative that activates the different pathological networks and then processes and provides healthier responses to those experiences (Alpert et al., 2020).

The robust literature in the efficacy of CBT for PTSD is substantial; however, current studies lack the outcome effects for people of color. Increased literature around the inclusion of diverse participants is slowly developing. As mentioned earlier, PTSD symptoms can present differently compared to race and cultures (Grau et al., 2022). CBT trials have mostly included White participants, and the effectiveness of CBT may be cautioned or questioned when generalizing to ethnic and racial minorities (Grau et al., 2022; Windsor et al., 2015). Clinical

trials of CBT are limited when showing the effectiveness of racial trauma, daily discrimination, and intergenerational trauma.

Prolonged Exposure

The PE approach is an evidence-based psychotherapy for PTSD. The PE approach is specifically integrated with CBT and exposure techniques that involves gradually recounting the fear-evoking traumatic memories that are avoided or distressing to help individuals manage their fears (Foa et al., 2018). Prolonged exposure was created by Dr. Edna Foa, the Director of the Center for the Treatment and Study of Anxiety at the University of Pennsylvania (APA, 2013). Prolonged exposure therapy for PTSD reduces the unrealistic anxiety and considers that avoidance of thoughts, people, or situations of a traumatic event, may impact maladaptive and negative beliefs (Foa, 2011; McLean & Foa, 2011; Watkins et al., 2018).

The PE approach has been used in many clinical trials for the past 20 years, specifically in military populations, and consistently demonstrates its efficacy (Foa et al., 2018; Reisman, 2016; Yoder et al., 2012). This evidenced-based approach uses two different techniques to treat PTSD such as imaginal exposure and in vivo exposure. Imaginal exposure is the exposure to an individual's thoughts or mental images relating to a traumatic event (Foa, 2011). This exposure assesses the client's emotions and feelings about their current thoughts and images. The other technique within PE is *in vivo* exposure, in which the individual is gradually exposed to specific types of stimuli within their actual environment related to the traumatic fear (APA, 2017).

PE is typically used in individual therapy ranging from eight to 15 90-minute sessions (Grubaugh et al., 2017). Due to the anxiety-provoking session in clients, mindfulness techniques and deep breathing exercises are used to help with anxiety symptoms. The goal of PE is to gradually decrease distorted beliefs about the traumatic event and assist with the reengagement

with life, people, and places that the individual has been avoiding (Foa et al., 2013). PE alters the distorted beliefs and processes a correction of information that can disconfirm the beliefs (Mclean & Foa, 2011). The symptoms of PTSD can be explained by the mind and body failing to process the traumatic event and memory by developing avoidance and the trauma reminders.

PE is one of the evidenced based practices that has shown promising effects of symptom reduction within a wide variety of traumatic experiences. One of the proposed directions of PE is shorter delivery of treatment, increasing immediate and long-tern efficacy, and continued research trials (Foa, 2011). The academic community has extensively explored clinical research trials of PTSD within the military population, specifically with women with experiencing sexual assault with rates at estimated 36% (McLean & Foa, 2011). Many trials have been conducted to compare PE treatment outcomes of military and veterans with civilians.

Steenkamp et al. (2015) conducted a review of randomized clinical trials of psychotherapy for military-related PTSD and found two-thirds of the participants who received CPT or PE showed no reduction of PTSD symptoms and still met the criteria for PTSD after treatment. In addition, one-fourth of participants in clinical trials dropped out during treatment (Steenkamp et al., 2015). Dropout rates of PE has continued to challenge and question the reasons for drop out during treatment which is similar to the proportions of the dropout rate in studies with civilians. Steenkamp et al. reported the most common reasons of VA and DOD individuals who do not seek treatment with a PTSD diagnosis and drop out of before completion of treatment is the internal feelings of stigma, the fear or confusion with patient confidentiality within the system, the time duration of treatment, and the lack of comfort with therapists.

Several scholars have agreed that the dropout rates of PE could be closely defined by the types of various types of trauma-related experiences. Although PE has shown to have efficacy

for PTSD, the treatment outcomes for active military and veterans are lower than civilians, and it is attributed the different trauma event, intensity of deployment trauma, and the repeated and extended exposure of traumatic experiences (Resick et al., 2003; Stenkamp et al., 2015). PTSD and the exposure of traumatic events are very common. It is estimated that six out of 100 people meet the criteria for PTSD (National Center for PTSD, 2022). The National Center for PTSD (n.d.) reported that 12 million U.S. adults will exhibit symptoms of PTSD each year. Across many studies, the higher number of traumatic experiences, can result in severe complex trauma (Foa et al., 2013; Resick et al., 2003). For example, Yoder et al. (2012) compared treatment outcomes of prolonged exposure among veterans of different wars. These scholars identified higher rates of PTSD symptoms after PE intervention in Gulf War veterans who experienced hypervigilance and fears of chemical or biological weapons, compared to other war veteran's experiences of active combat (Yoder et al., 2012).

There are many studies of PTSD that question differences in treatment outcomes for one group versus another. The process of correcting distorted beliefs the individual believes to be true and then uses information to correct those beliefs could be interpreted differently based on culture and race-specific experiences. In some cultures, the misinterpretation of one's experiences and using a corrective technique to disconfirm the beliefs, could cause invalidation of feelings and experiences (Sawyer et al., 2012). For example, race-related discrimination within the workplace could be interpreted as paranoia or distorted views, versus the individual experiencing implicit or explicit racism and discrimination, and culturally-sensitive treatment should be considered (Carter et al., 2018). The robust literature around prolonged exposure shares common limitations such as lack of diversity of participants and the relation of specific trauma characteristics versus others. Prolonged exposure therapy has shown to be a leading

evidence-based treatment for PTSD; however, future studies should continue to incorporate treatment outcomes of race-related trauma.

Anxiety Treatment

Anxiety disorders are one of the most common types of mental health presenting problems, and anxiety is ranked as the second leading cause of disease and disability (Garakani et al., 2020; Nyberg et al., 2021). It is estimated that anxiety affects 40 million people aged 18 and older within the United States; however, only 36.9% receive treatment (Anxiety & Depression Association of America, 2022), and there is a lifetime prevalence of 32% in the United States (Garakani et al., 2020). Women are twice as likely to develop anxiety disorders than men (Ghahari et al., 2020). The two most common anxiety disorders are panic disorders and social phobia, where the risk phases are more commonly developed in childhood and adolescence (Garkani et al., 2020; Seidl et al., 2020). Anxiety can be developed in many different ways, as a reaction towards a stressful event. The emotional response of fear is commonly shared throughout anxiety disorders (APA, 2022). Intense fear or avoidance of specific places, objects or situations accounts for over 19 million adults in the United States affected by specific phobia disorders (ADAA, 2022). The etiology of anxiety disorders is usually diagnosed in childhood; however, a number of scholars have observed common diagnoses in adulthood as well (Ströhle et al., 2018).

The academic community has extensively explored anxiety disorders and what many studies have found is anxiety disorders can reduce overall quality of life functioning, increase for risk of medical conditions such as cardiovascular disease (Nyberg et al., 2021). Garkani et al. (2020) reported that individuals with generalized and social anxiety disorder have high rates of persistent and recurrent symptoms, although some findings are inconsistent, Nyberg et al. (2021)

indicated that impairment in working memory performances are common. The discussion of the recurrence of anxiety disorders after treatment has gained importance over the years and revealed how the comorbidity of other mental disorders such as depression can cause the development of persistent anxiety disorders (Garkani et al., 2020; Nyberg et al., 2021).

Symptoms of anxiety can manifest as a variety of presentations. Avoiding emotions are one of the factors that are associated with higher levels of anxiety. Bardeen et al. (2014) examined emotional avoidance and severe anxiety. Their findings support using evidenced based interventions that include attention-based components to help with improving and reducing anxiety specifically social anxiety and generalized anxiety disorder (Bardeen et al., 2014). The increase of anxiety-related disorders has critically influenced academic dialogue on determining effective treatment interventions.

CBT

The effectiveness of CBT for anxiety disorders is based on a multimodal approach. As stated earlier, CBT is way to address and challenge faulty thinking, which is one of the notions of anxiety disorders with dysfunctional thinking patterns (Beck, 2011; Hoffman et al., 2010). The components of CBT in treating anxiety targets three prime areas: physical, cognitive, and behavioral approaches. CBT's long history in research and studies shows its efficacy in treating anxiety disorders (Hoffman et al., 2010). The treatment approach from Beck's model, can be applied to a variety of problems. The central component of CBT is that emotional and psychological distress is the effect of the unhelpful thinking patterns and beliefs about the world, themselves, and future outcomes (Beck, 2011; Hoffman et al., 2010). A large amount of research around the effectiveness of CBT for anxiety disorders shows improvement of symptom reduction after completion of treatment (Fordham et al., 2021; Hoffman et al., 2012), however in respect to

long-term outcomes, CBT has a small number of randomized control trials of the long-term effects of CBT lasting beyond a 12-month period (Ströhle et al., 2018). A meta-analysis of the effectiveness of CBT between various disorders, and populations, identified CBT provides symptom reduction across multiple disorders, and improves quality of living (Fordham et al., 2021). Fordham et al. emphasized the need for future research around diversity factors to adequately apply the effectiveness of CBT equally between groups.

The longstanding support and empirically supported treatments of CBT have proved its evidenced based practice through the growth of research studies, in contrast, researchers have prompted for CBT to include more diverse populations (Hays, 2009). Hays highlighted how CBT's strengths-based values are effective, efficient, and supported for the dominant culture such as assertiveness, individualistic independence, and behavior changes. In contrast, some cultures have an appreciation and values surrounding interdependence, collectivism, spirituality, and religious worldview (Hays, 2009).

Acknowledging the need for additional multiculturalism within evidenced based practices, there are studies developing and suggesting culturally adapted treatments within CBT (Ward & Brown, 2015; Williams et al., 2014). After a thorough review of the approach for anxiety disorders, meta-analysis and random control trials, CBT can substantially improve symptoms for anxiety treatment disorders. In the consideration of the African American population, it is suggested to conduct future research incorporating cultural identity values and faith-based approaches.

Pharmacological Treatment

Benzodiazepines are one of the most prescribed medications for treating anxiety disorders. This drug class has shown to be effective by strengthening the effect of

neurotransmitter (GABA), which is the primary (turn-off) signal in the brain (Garakani et al., 2020; Louvet et al., 2015). The fast-acting psychotropic medication provides immediate relief for acute anxiety, which is effective for short-term anxiety treatment (NIMH, 2022). The efficacy of benzodiazepines is well established, although controversial, and helps to reduce the intensity of anxiety and its physiological symptoms (Louvet et al., 2015; Sanderson & Wezlet, 1993). Benzodiazepines also are effective in reducing the cognitive expressions of worry and rumination. One of the controversial topics around benzodiazepines is the long-term use in treating anxiety disorders (Louvet et al., 2015). The prolonged use of benzodiazepines can cause impairment with cognitive functioning, depression, and vision problems (Chapoutot et al., 2021; Garakani et al., 2020). Liver functioning is one of the medical concerns, due to medications being metabolized in the liver (Garkani et al., 2020; Louvet et al., 2015). The severe downside of these drugs is the potential for addition and withdrawal, especially those who are using opioids or alcohol (Garkani et al., 2020; Louvet et al., 2015; Tjiong et al., 2020). The addiction and withdrawal from benzodiazepines can be dangerous, especially with abrupt discontinuation of long-time use (Chen et al., 2011; Pergolizzi et al., 2021). Rickels and Rynn (2002) described how prescribers should limit the medication to 2-4 weeks and then taper off gradually to reduce withdrawal symptoms and prevent relapse. Benzodiazepines and opioids are two of the most abused prescription drugs, and concurrent use was linked to five times the risk of an opioid overdose (Milani et al., 2020).

Selective serotonin reuptake inhibitors (SSRIs) are common medications prescribed to treat anxiety disorders. Many SSRIs are considered the first-line medication for many forms of anxiety related to long-term decreased symptoms. Most SSRIs can help to reduce worry and anxious thoughts, and there is evidence that supports SSRIs can lower the psychological

symptoms of anxiety such as insomnia, headaches, and muscle tension. The distinction and difference between the two drugs classes are that benzodiazepines take a shorter time to become effective and symptom relief within 30 minutes, while SSRI users may take up to 2–3 weeks to notice symptom relief.

When considering pharmacological treatment for anxiety, the most important factor to consider is addiction and withdrawal with benzodiazepines. As noted earlier, the lack of representation of racial and ethnic differences within anxiety research fails to provide an accurate understanding of efficacy in treatment in these populations. Cook et al. (2018) found that Caucasians have higher rates of prescription abuse of benzodiazepines compared to African Americans, Hispanics, and Asians. There is also scholarly concern about racial disparities within the prescription monitoring program disproportionately affecting Black people (Pearson et al., 2006; Suite et al., 2007). The continued cycle of healthcare disparities and past historical experiences of African Americans in the medical and mental health community may represent the need for alternative treatment approaches instead of medication management.

Mindfulness-Based Cognitive Therapy

Mindfulness-based cognitive therapy is the integration of techniques from CBT and mindfulness-based stress reduction (MBSR; Segal et al., 2002; Williams et al., 2008). Kabat-Zinn (1990) developed MSBR as a stress-reduction intervention through the techniques of mindfulness and yoga. Although the initial development centered on stress-management techniques, it has been extended as a treatment to help with a wide range of emotional, medical, and mental disorders. The approach of MBSR has increased in Western psychology research and practice with over 200 programs in North American and Europe (Niazi & Niazi, 2011).

Although MBSR is widely used there are some studies that examine the paucity of scientific evaluation (Niazi & Niazi, 2011). Anxiety symptoms can be reduced by the use of mindfulness meditation by lowering stress responses (Cramer et al., 2016). Mindfulness and meditation are derived from Indian or Eastern psychology, encompassing Buddhism and yoga practices (Singla, 2011). Singla elaborated how the goal of a peaceful mind is conscious awareness and experiencing an insightful and enlighten state. Roemer and Orsillo (2002) examined how the use of mindfulness-based practices with present-focused awareness can help to reduce the overall rumination with generalized anxiety disorder.

The long tradition and history of meditation has used mindfulness to promote calmness and body relaxation from unpleasant emotions. The popularity of meditation in the United States has increased significantly for coping with illness, stress, and overall well-being. The 2017 National Health Interview Survey reported that the number of U.S. adults using meditation tripled between 2012 and 2017 (NHIS, 2022). The MBCT uses similar skills as mentioned with CPT and CBT, by providing psychoeducation, and teaching individuals to become present-focused and mindful to disconnect from dysfunctional thought patterns (Williams et al., 2008).

MBCT is structured as a manualized 2.5-hour group-based skill program for 8 weekly sessions. The context within the skills program provides and teaches individuals to learn true aspects of themselves by accepting and tuning in to the present moment and not avoiding the cognitive experiences (Kaviani et al., 2011). Benefits of a MBCT program include improved insight, increased awareness, attention, and concentration, and development of coping skills for emotional, stress management, and self-care awareness (Cramer et al., 2016; Kaviani et al., 2011). There is emerging evidence indicating that aspects of mindfulness-based protocols are

also used in dialectical behavioral therapy and acceptance and commitment therapy (Hoffman et al., 2010).

Mindfulness-based cognitive therapy is supported by research to reduce anxiety, depression, and stress response. The limitations within MBCT are the small effect sizes and cultural demographics which reduces the generalizability of the findings (Radford et al., 2012). Mindfulness-based skills are similar to ethnical cultural values of faith and spirituality. Incorporating ethno-racial values within a culturally adapted mindful-based intervention would bridge the gap of lack of diversity treatments. Members of the African diaspora may benefit from parts of using MBCT for anxiety due to the ability of the intervention to promote peacefulness and mindfulness into the current present moment. Learning the true aspects of oneself mirrors the Nguzo Saba principles and African dance rituals to connect back to the cultural knowledge, identity, and healing practices.

Depression Treatment

CBT

The use of CBT has been one of the most widely studied approaches for treating depression and has certainly been one of the most efficacious interventions (López-López et al., 2019). Research trials have shown that using CBT is more effective than using pharmacological interventions alone, and it is effective as other psychotherapies (Gloagen et al., 1998; Hoffman et al., 2012; Siddique et al., 2012). Gloagen et al. (1998) conducted a meta-analysis determining that CBT for depression was more effective than antidepressant alone. These authors reported after CBT treatment only 29.5% of patients relapsed versus an estimated 60% who were treated with antidepressant's (Gloagen et al., 1998). It was developed to reduce negative thoughts and emotions that can lead to unhelpful behaviors.

Depression is one of the leading causes of disabilities that affects interpersonal, employment, and medical domains. When using CBT for depression, it is usually done over 12 to 20 sessions weekly, can be manualized, and provides very structured sessions. This approach is very similar to the techniques used for anxiety by identifying the cognitive patterns and developing appropriate coping mechanisms to challenge the negative thought patterns and dysfunctional beliefs (Cuijpers et al., 2010). The cognitive methods that are used to help depression often led to positive changes in depressive thinking and overall reduction in negative patterns. The CBT approach utilizes many interventions like cognitive reconstructing, activity scheduling, thought journaling, fact-checking, mindful meditation, and ABC analysis (activating event, beliefs about the event with underlying thoughts, and consequences of behavioral or emotional response). As mentioned with anxiety, CBT works with depression by challenging and changing the maladaptive thoughts and feelings (Beck, 2011).

CBT for depression was initially utilized as individual therapy, and as research and developments continued, it is available in group therapy, telehealth, and self-help protocols (Cuijpers et al., 2019; López-López et al., 2019). Cuijpers et al. (2019) conducted a meta-analysis and found that as an alternative to individual CBT, group, telephone, and self-guided treatments can be effective across diverse populations and a variety of different settings to help manage depression (Cuijpers et al., 2019). Although CBT is an effective intervention for depression symptoms, researchers should continue to explore the reasons behind the high dropout rates during treatment (Pentaraki, 2018).

One of the factors found within low effectiveness of CBT treatment for depression is the treatment delivery from psychology students versus psychologists (Pentaraki, 2018). Pentaraki investigated the high dropout rates, finding that African Americans along with other minority

groups showed higher dropout rates and responded poorly to CBT with case management services versus White participants. Previous studies have proven the need for additional studies on the effects of ethnicity and dropout rates, even though some clinical trials have shown a reduction of depression symptoms with a minority population (Pentaraki, 2018).

Several studies have been conducted to identify how patients using CBT for depression can develop the appropriate coping skills for lasting treatment outcomes. The findings of Hunter et al. (2002) on women with PMDD who received CBT sessions or antidepressants showed participants who received CBT sessions, reported improvements with their coping skills. In addition, in the study of Kuyken et al. (2010), the random control trial comparing MBCT and antidepressants, showed the patients who MBCT, showed significant increase in mindfulness skills. Learning and practicing the coping skills learned within CBT, can help with overall symptom reduction of depression. Hundt et al. (2013) explained the need for identifying the CBT skills that can most likely predict symptom reduction. Researchers have established how behavioral activation has shown efficacy of depression symptoms, and questions if the use of challenging cognitions in CBT can have the best treatment outcomes (Hundt et al., 2013).

As mentioned earlier, there are many studies that have consciously proved that CBT has high dropout rates. One of the observations of high dropout rates, is the challenging of beliefs and cognitions and replacing them with alternative thoughts. Despite the substantial evidence and literature on CBT for depression, members of the African diaspora may view the challenges of core beliefs and cognitions with relation to current racial trauma or daily discrimination as not feeling validated, supported, and understanding of their Black experience.

Pharmacological Treatment

The treatment of depression is one of the most important diagnoses, due to the high risk of suicidality. The CDC (2022) reported the 2020 statistics of suicide as the 12th leading cause of death of premature mortality in all ages. The National Library of Medicine (2020) describes the three most commonly prescribed antidepressants for the treatment of depression: tricyclic antidepressants (TCAs), selective serotonin reuptake inhibitors (SSRIs) and selective serotonin noradrenalin reuptake inhibitors (SNRIs). TCAs are one of the drug classes that have been approved by the FDA for the treatment of major depressive disorder (MDD). The medications used to treat MDD within this class include amitriptyline, amoxapine, doxepin, desipramine, nortriptyline, protriptyline, imipramine, and trimipramine (Moraczewski & Aedma, 2022). TCAs were the most prescribed class for depression until SSRIs were originated. TCAs decrease depression by increasing the levels of norepinephrine and serotonin while blocking the acetylcholine action neurotransmitter (Arana & Rosenbaum, 2000; Moraczewski & Aedma, 2022).

The medications in this class are used as a second-line options for patients who are not responsive to SSRIs and SNRIs. The TCAs are well absorbed with long half-lives, which suggest the medications has a slower rate of excretion out of the body and are typically dosed once at bedtime due to the sedating effects. TCAs are used as the second-line option of treatment for depression due to the high potential of lethal overdose that may cause seizures and the need for titration of dosages to reduce the side effects. The adverse side effects of this drug class may include dry mouth, blurred vision, constipation, drowsiness, low blood pressure, confusion (Arana & Rosenbaum, 2000).

SSRIs are often the most common medications used to treat depression symptoms; this class of medications is usually the first-line pharmacotherapy option for depression due to their efficacy, tolerability, and safety (Adams et al., 2008). Current SSRIs that are used include fluoxetine, sertraline, paroxetine, fluvoxamine, citalopram, escitalopram, and vilazodone (Arana & Rosenbaum, 2000). Serotonin is the neurotransmitter that helps to carry signals between the brain's nerve cells. Serotonin helps to regulate happiness and mood. Low levels of serotonin can cause depression and negative mood. An SSRI helps to decrease depression symptoms by increasing the levels of serotonin in the brain and throughout the body. The side effects of SSRIs are increased gastrointestinal problems such as nausea, upset stomach, diarrhea, decreased sexual effects, headaches, insomnia, and weight gain (Adams et al., 2008; Arana & Rosenbaum, 2000)

SSRIs have a well-tolerated oral absorption with half-lives from 15 to 75 hours. One of the risks of toxicity with SSRIs is the effect of serotonin syndrome with Monoamine oxidase inhibitors (MAOIs). MAOIs is a class of drugs for depression that is prescribed less often than TCAs, SSRIs, and SNRIs. The serotonin syndrome is considered a life-threatening drug reaction that is caused by the buildup of high levels of serotonin the body. Due to SSRIs' main effect of increasing serotonin in the body, and the effect of MAOIs' prevention of the breakdown of serotonin, high levels of serotonin can develop within 24 hours. The adverse effects and symptoms of serotonin syndrome include muscle rigidity, altered mental state, vomiting, and hypertension; severe cases can cause seizures, respiratory failure, coma, and death (Adams et al., 2008; Arana & Rosenbaum, 2000; Volpi-Abadie et al., 2013).

The drug class of SNRIs has a similar mechanism of action to TCAs by stopping the reuptake of serotonin and norepinephrine. This action helps to increase serotonin in the brain and increase the norepinephrine levels to help with improving concentration and reducing depression

symptoms. One of the caveats of the SNRI mechanism of action, is the potential for higher levels of norepinephrine which may cause panic attacks and high blood pressure and risks for gestational hypertension and preeclampsia during pregnancy (Calvi et al., 2021). The medications within this class are duloxetine and venlafaxine, desvenlafaxine, milnacipran, and levomilnacipran (Arana & Rosenbaum, 2000; Calvi et al., 2021). The most common side effects of SNRIs are nausea, dry mouth, headache, sweating, and dizziness (Arana & Rosenbaum, 2000; Calvi et al., 2021). SNRIs are of the drug classes metabolized heavily in the liver with half-lives from 11–12 hours. Voican et al. (2014) examined data related to severe liver injury from antidepressants and found MAOIs, TCAs, SNRIs (venlafaxine, duloxetine), SSRIs (sertraline), bupropion, nefazodone, trazodone, and agomelatine. One of the differences between the antidepressants is SSRIs and SNRIs show a higher safety and tolerability compared to TCAs an MOIs (Arana & Rosenbaum, 2000).

The long history and mistrust of the healthcare system continues to persist for African Americans as mentioned earlier within this study. Only 42% of African Americans reported that they would be willing to take the COVID-19 vaccine in the beginning phases of the pandemic. The medical mistrust is also defined as the lack of trust within mental and medical care for providers to give members of African diaspora equal genuine care of health insurance, best possible treatment options, and validation of concerns versus being discounted. Black people are less likely to report and seek treatment for mental health concerns, and they commonly resist psychiatric medication treatment for issues (Lesser et al., 2011). Due to this, an alternative cultural intervention diminishing the use of medication, could help with increase treatment outcomes and reduce issues with alcohol and illegal substances.

Music Therapy

Music therapy has been linked to connecting positive emotions, feelings, and overall well-being in individuals. Although music therapy is an alternative approach to evidence-based treatments, some research proves music and creativity can increase dopamine levels which induces happy moods and pain relief. Music has also shown to facilitate a reduction in stress and the hormone chemical cortisol, which can improve mood. Additionally, oxytocin can help be released with live music and playing music with others. The history of music therapy for mental health began during the early 1900s by using music within institutional settings and hospitals, overtime research on the use of music and medicine began to develop (Chen et al., 2011). During the early studies, researchers conducted randomized control trials to determine areas within mental health that would receive the most benefit. Hole et al. (2015) conducted a meta-analysis and found that music reduced postoperative pain, and Sarkamo et al. (2008) concluded that music listening can help with the recovery of verbal memory and prevent symptoms of depression after an MCA stroke. Music therapy research became more robust around cognitive and emotional benefits in dementia patients (Chen et al., 2011; Cooke et al., 2010; Guetin et al., 2009). As researchers have continued to explore the cognitive benefits music, many studies found music can decrease anxiety, depression, sleep quality of insomnia with adults, and improved long-term memory (Jespersen et al., 2015). The depression symptoms of lack of interest in activities and feelings of worthlessness, can be improved by music stimuli engaging specific brain functions (Chen et al., 2011). The American Music Therapy Association (2022) found that music therapists can link a client to their psycho-emotional state quickly and enhance their social, interpersonal, affective, and behavioral functioning.

Limitations within music therapy studies are limited control trials with small sample sizes, cost-effectiveness, publication bias, and diversity of participants (Kamioka et al., 2014). The universality of music may show advantages in reducing depression for minority populations, by including cultural traditions and values within the intervention.

Limitations of Current Models

A considerable amount of literature has been published on the evidence-based primary treatments of trauma. Data from several studies have identified CPT as the gold standard in treating related symptoms. The literature search found most of the studies on CPT were used among U.S. military personnel and veterans within individual or group formats. Nearly 49% of the clinical trials showed no demographics of race. Race plays an important role in understanding how effective treatment can be developed for minority populations successfully. The lack of representation of African Americans poses a significant concern in clinical trials (Lamp et al., 2019). Clinical trials with CPT have long been acknowledged to have high drop rates (Najavits, 2015). Patients completing CPT treatment ranges from 16% to 42% (Najavits, 2015). It has been conclusively shown that African Americans were significantly less likely to complete CPT treatment compared with Caucasians, and Caucasians showed greater symptom reductions in PTSD and depression symptoms (Lamp et al., 2019; Najavits, 2015).

The results of several studies have revealed that CPT is an effective treatment for posttraumatic stress disorder. The race demographics of the clinical trials of CPT, CBT, and PE have shown to be used primarily with Caucasian patients. The lack of diversity within generalizability within randomized clinical trials communicates inconclusive treatment outcomes for people of color. In addition to the lack of African Americans within control trials, the absence of reporting race demographics leaves a significant gap in the robust literature review to help

develop an effective treatment for minorities. Dropout rates have remained a continued problem for evidenced-based "gold standard" practices, specifically CPT and PE. Detailed examination of African Americans and Caucasians showed that African Americans are more likely to end CPT before completion compared to Caucasians. Out of those African Americans who complete CPT, they are less likely to reduce PTSD symptoms (McClendon et al., 2020)

The main limitations to the previous studies are: (a) lack of representation of minority patients, specifically African Americans, (b) high dropout rates of African Americans compared to Caucasians, and (c) cultural considerations of evidence-based treatment for patients who are non-White. Previous researchers have failed to address the vital need for treatment options that can work for clients of African American backgrounds. The understanding of why CPT, CBT, and PE show lower reductions in African Americans is still inconclusive. There is a lack of direction within the literature that addresses how effective CPT, CBT, and PE is for African Americans.

The findings of this study capture the limitations of the current treatment's approaches for trauma, anxiety and depression. The evidenced based approach of CPT for trauma proved an effective intervention with a higher rate of treatment outcomes for Caucasians versus minority populations. The high dropout rate for CPT participants substantiates the question of the effectiveness for minority populations and the reasons for their highest dropouts (Najavits, 2015). Many clinical trials of CPT included samples of mostly of military and veterans and lacked the report of comparison between racial demographics and specific trauma experiences to include racial trauma.

The empirical results of CBT and TF-CBT has similar limitations found within this study. The clinical trials and observational studies indicate the large population of White participants in

research studies. They are, therefore, subject to biases and confounding estimates regarding the efficacy of cognitive therapy for people of color. The conflict arising from cultural bias is the lack of minority participants and the small effect sizes if using people of color. The lack of previous research comparing a culturally adapted intervention with an evidenced based intervention could generate and establish effective outcome treatments for the symptoms of trauma, depression, and anxiety.

Overall findings within this study indicated several limitations around cultural bias, effect sizes, demographics, and limited research. Prolonged exposure therapy for trauma presents limitations with comparing specific types of traumas related to race and culture and its effectiveness. Antidepressants for depression and anxiety established decrease of symptoms; however, members of the African diaspora have been shown to experience more chronic symptoms. The mistrust of the medical community and health disparities could continue to hinder African Americans who are seeking treatment.

What Now?

Given the current evidence-based practices for trauma, anxiety and depression, research patterns indicate the lack of generalizability within studies and without cultural adaptations are not as effective for African Americans compared to Caucasians. African Americans experience a perpetuating cycle of medical disparities due to a lack of appropriate interventions related to culture, which further oppresses and contributes to any pre-existing racial trauma. The call for increased literature and clinical studies for minorities has continued for the last 10–15 years; however, the minimal effects of existing studies have shown limited progress forward. Hundreds of clinical trials provide patterns within their limitation and falls short of comparison with racially-related symptoms, limited trials of minority participants, and comparing culturally

adapted interventions versus current evidenced-based interventions. In this paper, the researcher sought to advocate for the increased study of culturally adapted interventions.

CHAPTER III: CULTURALLY SPECIFIC INTERVENTIONS FOR BLACK CLIENTS

Black people are just one of the minority populations that suffer the highest chronic rates of trauma and depression while receiving low rates of appropriate medical care (Bailey et al., 2019). Other cultural health disparities include poverty, low SES, discrimination, and limited cultural interventions (Shephard et al., 2018). In this chapter, the researcher examines and critiques the clinical trials of interventions that were designed specifically for people of color. Culturally sensitive methods address a gap in the literature on the interchange of African American experiences of racism and trauma. The gap is perplexing because there is a need to integrate the background and cultural considerations within research to help determine the best treatment methods for people of color. Culturally specific interventions are a monumental step forward, and cultural awareness can inform the development of a more meaningful and valuable approach to care for Black people.

Cultural Interventions for Trauma in African Americans

There are many universal techniques designed to treat trauma. Regarding the specific cultural needs of African Americans, only a few interventions have been developed. Due to limited research and few clinical trials of specific treatments for African Americans, many of the suggested adaptations that are discussed are not evidence-based. CBT and prolonged exposure is two of the most empirically supported interventions for the treatment of PTSD. Williams et al. (2014) proposed a culturally informed adaptation of PE that integrates themes of race-related trauma relevant to the Black experience. Race-related trauma can consist of frequent microaggressions, hate crimes, and physical assault (Williams et al., 2014). The adapted PE protocol was developed to help address the difficulties of developing and building trusting therapeutic alliances, navigating the conversation of racial issues within trauma, and the

integration addressing the racial themes during therapy. The essential factors of this study highlighted that clinicians should have a basic level of understanding cultural sensitivity factors within formal education or immersive experience with individuals of the cultural group. African Americans have the highest racial disparities than any other ethnic group for being misdiagnosed due to a lack of cultural sensitivity and cultural knowledge considerations (Gara et al., 2019). Formal assessments within the Williams et al., (2014) study emphasized how gathering standardized assessments with the inclusion of racism-related trauma is key to understanding the full comprehensive cultural trauma symptoms of African Americans. These scholars initially administered the Posttraumatic Diagnostic Scale (PDS) and the Standardized Trauma Interview (STI) for the initial assessment of PTSD symptoms. Specific assessments were administered to address the factors of cultural constructs such as racism-related stress, spiritual or religious beliefs. Williams et al. administered the Multidimensional Inventory of Black Identity for African Americans, the Multigroup Ethnic Identity Measure (MEIM), the Schedule of Racist Events (SRE), and the Brief Religious Coping (Brief-RCOPE) self-report measures. In addressing the depressive symptoms, the self-report measure Beck Depression Inventory-II (BDI-II) was administered.

Their first session of this cultural PE involved the assessment and psychoeducation of providing the patient with an overall rationale for using PE and ensuring the patient understands the treatment program (Foa et al., 2018). Like Edna Foa's prolonged exposure in Session 1, Williams et al. (2014) additionally incorporated how racism can be a factor in developing PTSD symptoms. Specifically, the authors presented data to the clients on the mental health consequences of racism and discrimination factors to help promote the therapist's cultural awareness and build the foundation for trust within the therapeutic alliance. The *in vivo* exposure

component for African Americans would involve the race-related trauma and construct a hierarchy that examines those race-related fears such as being exposed or interacting with individuals of particular backgrounds. For example, if a client has fears of police officers, *in vivo* exposure may include starting a conversation with a police officer in passing. During imaginal exposure, it is essential that the therapist have a comfortable and appropriate level of discussing race and does not minimize the client's race-related concerns. Conducting the processing after the imaginal exposure for African Americans includes using Socratic questioning, acknowledging that their experience is validated, and encouraging clients to see experiences of racism as a reflection of the individual carrying out the racism versus themselves to help reduce re-traumatization (Williams et al., 2014). One of the study's case samples used PE for racism-related PTSD and incorporated Afrocentric principles of resiliency, optimism, faith, and family support. After using the application of the culturally adapted PE intervention with Afrocentric principles of the case sample, the client's symptoms greatly improved. The results of this proposed culturally adapted treatment illustrates the necessity to incorporate cultural principles within PE therapy. Eurocentric measures are currently the standard for PTSD interventions; however, this culture-related adaptation may improve cultural sensitivity and strengthen the treatment outcomes of PTSD in African Americans.

Cognitive behavioral therapy can be used specifically with African Americans due to the elements of race-related events that can reflect a psychological state prompted by cognitive processes. Cultural adaptation in CBT for cultural groups can include (a) validating the client's negative experience within race-related events, (b) teaching and helping clients practice changes reducing distress, (c) developing awareness of strengths within the ethnic background, and (d) encouraging clients to challenge negative thoughts (Hays, 2009). As previously mentioned, a

therapist's ability to discuss race and acknowledge and understand the African American experiences is the foundation of creating a culturally adapted CBT intervention (Beck, 2011).

Similarly, Graham et al. (2014) proposed enhancing the multicultural sensitivity of using CBT for anxiety in diverse populations. These authors advocated several ways to broaden CBT interventions for diverse populations by having clinicians learn and educate themselves of the range of individual experiences by any diversity group, continuing the conversation around race-related experiences and discrimination to help provide appropriate cognitive reconstructing, increased validation and knowledge by providing psychoeducation related to the experiences of anxiety specifically for each individual, offering culture based cognitive recon structuring to enhance thinking patterns and decision making, and modifying exposure situations that addresses cultural understandings and values (Graham et al., 2014). The inclusion of multicultural adaptations within evidenced-based practices is in high demand due to the large diversity population within the United States, which increased from 36.2% in 2011 to 61.1% in 2020 (Graham et al., 2014; Sue et al., 2009).

The culturally adapted CBT theory of Steele and Newton (2022) highlighted how a cognitive framework model with African Americans related to internalized racism might include core beliefs of inferiority to White culture, inadequacy around being Black, personal blame of racism attacks, and powerlessness of the lack of change or continued cycles of oppression in the media. Additionally, the compensatory strategies of African Americans within the CBT model may include avoidance by internalizing feelings of shame or isolation to prevent reinforcement of negative stereotypes. Other compensatory strategies may include conformity to the dominant culture, over-performance, and learned helplessness from perpetuating cycles of racism (Steele & Newton, 2022).

Their proposed theory supports integrating cultural context factors such as broaching and multicultural orientation (Day-Vines et al., 2020; Hook et al., 2017; Steele & Newton, 2022). The term *broaching* refers to the genuine intentional and deliberate efforts of the counselor to explore the open conversations about any racial, ethnic, and cultural difficulties affecting the client's current concerns (Day-Vines et al., 2020). The term *multicultural orientation* refers to the way counselors think about the diverse backgrounds and values of clients (Hook et al., 2017). Multicultural orientation concentrates on the "way of being" in therapy with clients of diverse backgrounds, incorporating cultural humility, employing cultural comfort, and utilizing the moments of addressing cultural concerns (Hook et al., 2017)

The cultural African American framework of CBT by Steele and Newton (2022) emphasizes the assimilation of the primary model of CBT by identifying and challenging negative thoughts and beliefs and, most importantly, providing the space for empowerment, validation, and affirming the individual's cultural identity. A culturally adapted model of CBT begins with the foundation of counselors' awareness of their own biases and understanding of their comfort with race-related conversations with clients and peers. This framework was able to consider the common core beliefs, schemas, and compensatory strategies that can be applied to individuals experiencing internalized racism.

Mindfulness-based interventions can play an important role with reducing anxiety, stress, and improving blood pressure of African Americans (Kabat-Zinn, 1990; Hoffman et al., 2010; Palta et al., 2012). Woods-Giscombé and Gaylord (2014) explained considerations for bridging the gap of medical disparities among African Americans women by Mindfulness-Based Stress Reduction, Loving-Kindness and the NTU therapeutic framework. NTU (pronounced “in-too”) psychotherapy was founded by Dr. Frederick Phillips based on an African Bantu concept that is

spiritually based and incorporates the ancient African core principles of Kwanzaa and Nguzo Saba as a guideline (Karenga, 1997; Phillips, 1990). NTU psychotherapy focuses on five principles—harmony, balance, interconnectedness, cultural awareness, and authenticity—that can influence the response to challenges of daily living (Phillips, 1990). Woods-Giscombé and Gaylord (2014) described how the use of NTU psychotherapy is helpful for the decrease of health disparities by becoming aware of self-barriers for desired closeness in interpersonal relationships, and promoting the inclusion of peaceful and calm relaxation. Their study supports the emphasis of how mind-body interventions can not only attribute to well-being with lower cost options, but also how a holistic cultural approach can be acceptable to African American women. This article describes the mind-body approaches of MBSR, LKM, and NTU, and the current researcher agrees that further research of the three interventions could strengthen the empirical research and evidenced-based practices for these holistic interventions for members of the African diaspora.

Grills et al. (2016) examined how racial stress within members of the African Diaspora has developed unimaginable trauma from the perpetuating cycle of racism. These scholars thoroughly explained how past deceit and lies of the Black Community, can be healed through Emotional Emancipation Circles (EEC) to help heal trauma caused by anti-Black racism (Grills et al., 2016). EECs were created by the combination of the Community Healing Network (CHN) and the Association of Black Psychologists (ABPsi) to provide a space for members of the African diaspora and recreate the Black negative perceptions, beliefs, and values once destroyed by White people (Grills et al., 2016). EECs promote empowerment in the Black community, psychological freedom, and emotional healing from trauma (Grills et al., 2016). Three central tenets of emotional emancipation are: (a) facilitating liberation and freedom from the deception

and lies about the Black culture, identity, and values; (b) increasing self-esteem and acceptance of positive identity and character such as beautiful and worthy; and (c) healing the intergenerational trauma from slavery to current continued oppression (Grills et al., 2016).

Chioneso et al. (2020) addressed how racial trauma can be healed through a cultural framework of the Community Healing and Resistance Through Storytelling (C-HeARTS). The C-HeARTS framework uses the concepts of justice and healing to not only embody cultural integrity with ensuring a community is thriving, but to use storytelling as a way for others to connect by hearing personal stories to reframe negative thoughts and produce positive thoughts (Chioneso et al., 2020). Similarly, Parks (2007) explained how African American folklore and narrative stories such as overcoming adversity and discussing strategies for coping skills can promote healing in traditional cultures. The themes that help to create a therapeutic alliance of the folk belief system are spirituality, ritual, and dreams (Parks, 2007). Spirituality is used within this context as the personal belief and awareness of ones understanding of their values that can create a peace of mind. Rituals within African American folklore includes a shared group of ceremonial procedures that can channel energies of others to help promote healing and relief of stress (Parks, 2007). Dreams and spirituality share a common relationship within folk healing by the belief of omen and future events that are interpreted as symbolic meanings (Parks, 2007).

Parks (2007) thoroughly considered alternative cultural therapy for African Americans and highlights the key component of connecting back to the culture by using past traditions for healing. Parks reported that 38% of African Americans have a family member associated with believing in folklore, and 51% have heard storytelling from earlier generations. The integration of faith-based concepts, reuniting with tradition, and developing connection to community values supports how Nguzo Saba principles and traditional dance rituals can be effective mental health

treatments. The limitations of this article using the proposed C-HeARTS framework to help promote communal healing are as follows: (a) There is an undefined process of connecting the various components of community healing and how it can be explored and (b) This framework allows for a holistic intervention which may appeal to many members in the African diaspora, but it solely applies to racial trauma versus other trauma experiences.

Cultural Interventions for Depression in African Americans

A culturally adapted depression treatment in African American women was developed by Kohn et al. (2002). In developing this treatment, the scholars modified a similar depression CBT group protocol from Munoz and Miranda (1986). Kohn et al. (2002) integrated Aaron Beck's CBT primary interventions and the inclusion of structural and didactic adaptations. The author's structural adaptation included: (a) limiting group therapy specifically to African American women with major depressive disorder, (b) keeping group sessions closed to help facilitate the cohesion of group members, (c) adding immersive experiences with the inclusion of meditative activities and incorporating ritual conclusion after a 16-week intervention, and (d) adapting primary cognitive-behavioral language to a more inclusive and connected African American experience. For example, using the term "homework" within the CBT language is changed to "therapeutic exercises" to alleviate the stigma or non-cultural therapeutic language. The didactic adaptation is referred to the content used within group therapy, which consists of the four culturally specific sections as part of the therapy module. The four culturally specific models are as follows: (a) creating healthy relationships, (b) spirituality, (c) African American family issues, and (d) African American female identity (Kohn et al., 2002). With the cultural models in mind for adopting an African American treatment intervention, these authors explored a way to represent cultural factors and address the cultural concerns of African American women who

seek treatment. Kohn et al. described how their adaption of CBT and adapted cognitive behavioral therapy (ACBT) resulted in a decrease of 12.6 points from pre to post-BDI depression symptoms and women within the group exhibited a decrease of depression symptoms twice more than the women in the original CBT group. The conclusions of Kohn et al. indicated the need for increased study and application of culturally adapted treatment for specific diverse populations.

The use of indigenous healing systems with members of the African diaspora has gained scholarly attention in recent years. There is evidence that seeking help from indigenous healers can have promising effects of people of color with depression symptoms (Whaley, 2020). The consensus of Western health views of indigenous healers for members of the African diaspora is considered a cultural alternative and complementary medicine (Whaley, 2020). Whaley investigated the different hypothesis regarding the correct correlations between psychotic experiences and indigenous help-seeking findings. This author's findings suggest that members of the African diaspora could benefit from the use of indigenous healers for mental health symptoms as evidenced using indigenous healers of African Caribbean individuals for neurotic conditions (Whaley, 2020). The current study offers an additional cultural-based intervention other than the use of Western counseling practices. One limitation within this study is the effect of diversity within members of the African diaspora and would the indigenous healing create the same treatment outcomes. Finally, future research may provide a comparison of the treatment effects of the types of indigenous practices with other depression related interventions.

Limitations

There is a very limited amount of literature published on the cultural interventions used for African Americans in treating trauma, depression, and anxiety. After reviewing the data, several key themes emerged: (a) counselors treating African Americans should have a basic level

of understanding of their own biases and stereotypes regarding race-related concerns; (b) counselors should have prior knowledge of cultural competence and cultural awareness of African Americans; (c) counselors are encouraged to address race-related concerns and provide genuine conversation in understanding and validating race-related difficulties; (d) interventions specifically for cultural adaptation needs additional assessments targeted to various cultural trauma symptoms; and (e) allowing space for Afrocentric principles such as resiliency, empowerment, optimism, faith, family support and positive self-identity (Gara et al., 2019; Hays, 2009; Kohn et al., 2002; Steele & Newton, 2022; Williams et al., 2014).

There is a high demand for recommendations and implementations for cultural considerations in treating African Americans. Cultural frameworks are being developed and proposed to help understand, support, heal and provide the best therapeutic experience for African Americans.

CHAPTER IV: TRADITIONAL AFRICAN DANCE

Traditional African dance is representative of more than just music, rhythm, and movement. The various forms of African dance originated as an expression of prayer, a form of emotional communication, a rite of passage, and more. Many African societies emphasize individual aspects within a communal and spiritual connection. Healing practices treating specific ailments within Africa emerged as ritualistic and spiritual dances that helped embrace the social, physical, and mental realms of healing. Dance is used by Africans to translate their feelings, emotions, and experiences into a form of expression for a communal group. Dance is also used to connect the living with their ancestors (Brooklyn Academy of Music, 2022). Monteiro and Wall (2011) illustrated themes relating to the conceptualization of health and illness in Africa:

> Some of the themes linking the attitudes, beliefs, and behaviors related to illness throughout Africa include communalistic social structures, lifestyles that encourage harmony with environment and nature; the prominence of spirituality in the worldview; belief in both natural and supernatural causation of illness with the acknowledgment that most theories are culture-specific; and the frequent use of religious/spiritual healer to treat illness. (p. 234)

The American Dance Therapy Association (2022) has defined dance and movement therapy as the link between psychotherapy and movement techniques that promotes overall well-being by healing the emotional, social, cognitive, and physical aspects of an individual. Alternative interventions of Afrocentric dance can be useful by connecting the cultural and communal identity of people of the African diaspora. Through an exploration of these approaches in the

current study, the researcher showcased a gap in the literature pertaining to a lack of theory-driven, culturally informed research for people of the African diaspora.

A lack of evidence-based treatments integrating trauma and dance was the impetus of this project. Judith Hanna examined the anthropological study of dance. This author explained,

> To dance is human and humanity universally expresses itself in dance [through its ability to] interweave with other aspects of human life, such as communication and learning, belief systems, social relations, and political dynamics, loving and fighting, urbanization, and change. (Hanna, 1979, pp. 3–5)

Hanna further highlighted how dance can illustrate the physical embodiments of one's feelings or thoughts, stating that it can be more effective than using verbal language to communicate one's desires or needs.

Ndeup

Monteiro and Wall (2011) described different types of dance rituals that are used for healing trauma symptoms in Africa and North America. These African cultural practices resemble similar spiritual cultured rituals from diverse religions. One of the African dances explored is the Ndeup ritual, originating in Senegal. The Ndeup is a cultural and spiritual therapeutic ritual that welcomes the entire community to join in the ceremony. This Senegalese ceremony is a ritual of possession from the protection of evil spirits that connects the individual (i.e., patient) to their ancestors and their spirits (Monteiro & Wall, 2011). The ceremony consists of sacrifices of animals, setting up an altar, reciting ritual words with music of drums, and women singing ritual songs to the ancestors and spirits. During the ceremony, which can last 4 to 10 days, the patient may become alert and begin to dance.

The movements within the dances are described as free movement and unchoreographed dancing, which is one of the essential elements in carrying out the ceremony. In the act of helping this patient with their illness, this dance creates a space for those to release mental, physical, or spiritual feelings in a community healing setting. Although the ceremony is conducted in the open and in public, the music and dance provide a sense of protection to the patient to "break down" the barriers, leading to feeling isolated, unprotected, and vulnerable. The ritual acts as treatment by creating a space to develop a cathartic experience. The Ndeup ritual—like other forms of cultural tradition for healing—incorporates meaning with each dance, the millet, the beat of drums, prayers, and songs. Monteiro and Wall described how the patient experiences a freeing and cleansing feeling through the vibrantly dressed participants, the array of food, and the dance compositions of dancers who may twirl and jump passionately.

Zar

A similar cultural tradition named Zar is one of Egypt's oldest dance practices. Zar is a ritual that involves a spirit that one possesses, the actual state of being afflicted, and the healing ceremony (Monteiro & Wall, 2011). This ritual has similar principles to Christian and Islamic symbolism. In Christianity, the call of God or other deities to help with protection and with Muslims, inviting the power of Islamic spirits, is called *jinn.* Zar is practiced in Egypt, Sudan, and Ethiopia by Muslims, Christians, and Jews. Zar is a type of rhythmic healing system that also involves the physical, spiritual, and relational realms. Similar to the Ndeup ceremony, Zar consists of a ritual with food, singing, dancing, music of drums, and repetitive trance states. Once again, cultural dance traditions work through a group healing process that helps to heal the body, mind, and soul. Zar's healing is known through the support of community and family, helping to create an emotionally cathartic experience (Monteiro & Wall, 2011).

Other Regional Dances

In Egypt, Eskista is a traditional complex Ethiopian dance performed by women and men. It involves the dancers rolling their shoulder blades and contracting the chest. This traditional dance, which is popular in various areas of Ethiopia, is performed within different ethnic groups (Martin, 1967). Eskista's movements can communicate joy, pain, and happiness, and it can be performed for occasions such as marriage, festivals, and religious ceremonies in both indoor and outdoor settings (Ashagrie, 2021; Carter et al., 2018). The Eskista dance is a way to express and symbolize dancers' feelings, happiness, and struggles through body language to promote healing (Ashagrie, 2021; Carter et al., 2018).

In Guinea, there is a common dance called Moribayassa that is performed by women that have overcome great adversity. Moribayassa consists of musicians who sing and dance, circling their village. The Moribayassa old rhythm dance has intricate rhythms and is performed to celebrate one the most prominent problems within one's life that has been resolved. Once the Moribayassa dance has been completed, the individual who sings and dances to the rhymical beat buries the clothes danced in to represent that the problem has been solved and that they are healed and able to move forward (F2FAfrica, 2021).

The Democratic Republic of the Congo uses a West African traditional form of psychotherapy called Zebola, a women's spiritual possession dance. The Zebola is a dance that helps to work through difficult issues of young women and how cultural change can develop various conflicting expectations (Vinesett et al., 2015). The women who perform the dance usually experience emotional distress that, at times, manifests as physical symptoms, and performing the Zebola can help decrease these somatic symptoms (Vinesett et al., 2015).

The Vimbuza is a healing dance used in Malawi for patients who suffer from mental illness (Msosa, 1999). Spiritual healers treat patients from weeks to months with a healing ritual that involves women and children in the village circling the patient and singing songs with specific drum rhythms (Msosa, 1999). This dance, in combination with singing and drumming, creates a space for the patient to "dance their disease" in an intense, vibrant atmosphere (Msosa, 1999).

African dance has evolved into a plethora of cultural and modern variations of dance styles. Krumping is a more modern artistic dance of emotional expression among African Americans. Traditional African values of community support, collective identity, personal freedom, and spiritual awareness encompass the krumping dance. The free-form expression of krumping consists of energetic, jerking, and quick, intense emotions through the face, hands, shoulders, legs, and main body. The style of krumping evokes and releases the dancer's emotions through the expression of movement and facilitates personal growth, self-esteem building, and healing (Monteiro & Wall, 2011).

After completing 41 reviews of Afrocentric dance rituals used specifically for Black people with mental health symptoms, the current researcher identified that scholarly explorations of this topic are limited. The health benefits of African-centered dance were a common theme throughout the existing literature (Conner et al., 2021; Koch et al., 2013; Mala et al., 2012; Monteiro & Wall, 2012). The findings of six studies highlighted a statistically significant decrease in the depression of participants who engaged in dancing in circles and moving to rhythms as a form of exercise (Koch et al., 2013; Mala et al., 2012; Monteiro & Wall, 2012).

Bitterman et al. (2001) were among the first pioneers to conduct an experimental intervention with the use of drum circles in music therapy. In their study, they emphasized

camaraderie, group acceptance, lighthearted participation approaches, and nonjudgmental performance. Their data demonstrated statistically significant modulations of specific neuroendocrine and neuroimmune parameters that contribute to the elevation of well-being.

Fancourt et al. (2016) conducted a clinical trial on the mechanisms of group drumming to improve mental health over several weeks. These investigators hypothesized that participants would have decreased anxiety and depression symptoms over a 10-week randomized control trial. Their results demonstrated that drum circles in a group could reduce anxiety and depression and improve social resilience.

Vinesett et al. (2015) examined themes of how the African dance ritual Zebola from the Congo can be used in the United States to decrease depression and anxiety. The themes of the participants were (a) altered awareness, (b) experience of positive energy, (c) improved sense of balance, (d) experience of stress reduction, (e) drums as grounding experience, and (f) intention while dancing. A later pilot study conducted by Vinesett et al. (2017) integrated the traditional African dance of the Ngoma ceremony with mindfulness-based stress reduction. This study consisted of dance steps with drumming and rhythmic music and the MBSR intervention of learning mindfulness-based techniques. The results showed improvements in depression, anxiety, emotional well-being, and social functioning. This pilot study is one of many with findings showcasing the mental health benefits of applying West African healing ceremonies (Koch et al., 2013; Mala et al., 2012; Monteiro & Wall, 2012; Vinesett et al., 2017). Overall, the literature review provided the importance of continuing to develop research on the effects of African dance and its impact on mental health. The integration of spiritual, physical, emotional, cognitive, and social aspects is not only central to the treatment of mental health, but also to the enlightenment of relatedness to oneself and others (Zubala, 2013).

Limitations and Moving Forward

Many researchers have indicated that dance movement therapy is effective in reducing stress, depression, and specifically trauma-related symptoms of PTSD. West African dance is a practice of spiritual well-being, which is a centerpiece strength of African Americans. The African retention of ancestors, history, heritage, and spirituality can enable dancers and watchers to cultivate a positive sense of identity. Dance, chants, and music, consisting of drums, promote self-discovery and identify formation necessary for the development of self-esteem and self-image. The psychological application of drum circles is currently used therapeutically to mitigate the emotional pain of PTSD, displace anger and negative emotions, release stress, and promote group cohesion and belongingness.

Dance rituals are similar to mindfulness practices, in that both focus on the here and now. Scholarly findings have suggested that West African dance can help promote overall well-being, specifically positive physical, mental, and social health (Conner et al., 2021; Mala et al., 2012; Monteiro & Wall, 2012). The submersion of an individual within a supportive community and culture promotes their self-confidence. Although there is limited research in the field on West African dance rituals used in the United States, scholars have recommended integrating drumming circles as an alternative to mindfulness and trauma-informed care programs. As mentioned earlier, dance movement therapy is an appropriate, low-cost, effective, age-related therapeutic interventions for PTSD, depression, and stress reduction in Black people. By summarizing the available data, it becomes evident that Black people would benefit from a rhythmic mind/body approach that is client-centered as a whole-person approach connecting to cultural identity.

The effects of African dance rituals on Black people show promising results in reducing mental health symptoms; however, the results of clinical trials have not supported three prominent themes. The first theme is addressing the longevity of decreased mental health symptoms of drumming circles in African dance rituals. Secondly, there are insufficient data comparing the effectiveness of culture drumming-specific methods with Western psychotherapies. Future researchers should address the complete picture of both interventions to specify how effectively adapted cultural traditions can be beneficial for Black people compared to western interventions. Thirdly, there is a need for additional research on other cultural-oriented dances in clinical trials to better understand the benefits specifically for African Americans and the relationship to health outcomes.

In order to create an Afrocentric value orientation for Black people, it was necessary to evaluate and compare clinical trials that showcase the link between African ritual dance and the decreased symptoms of anxiety, depression, and PTSD. After examining these clinical trials, the current researcher concluded that Afrocentric dance rituals can be effective in reducing anxiety, depression, and PTSD symptoms for Black people. To create an adapted cultural treatment program, further research is required to bridge the current gap in addressing the lasting effects of the African diaspora.

CHAPTER V: FUTURE DIRECTIONS AND PROPOSED MODEL

Through this paper, the researcher advanced the idea that culturally adapted interventions have been a need for minority populations. The continued racial oppression that African Americans face in society is manifested in many ways, including medical disparities. It is necessary to continue addressing this need and proposing interventions to advance this movement. The major findings in this study indicated that only average of 43% of the research articles report data on race and ethnicity. Out of all the limitations found, this average is one the propounded impacts within this study, with a relatively high misinterpretation on the outcome of evidence-based treatments with African Americans and other people of color.

In relation to past findings, the most important is the absence of reporting race demographics. This leaves a significant gap in the robust literature review to help develop an effective treatment for minorities. This includes determining whether evidenced-based practices are applicable for African Americans/Black people—and, if treatment was not successful, then explaining their hypothesis of the reasons. The surprising results of this study revealed that out of the clinical trials analyzed, they showcased general support for diverse race and ethnicity treatment outcomes, however; there is a special need for intergenerational trauma, and cultural values to the integrated within the interventions. The researcher's goal is to propose a value-based African orientation with mindfulness principles of African dance to improve self-discovery, self-esteem, self-belongingness, and psychological stability.

The value-based African orientation proposed is Sankofa cultural therapy (SCT). Sankofa is a Ghana term and symbol meaning reaching back to knowledge gained in the past and bringing it into the present in order to make positive progress. SCT is based on principles of Nguzo Saba and African dance rituals to promote empowerment of culture, identity, healing, and community.

The elements include (a) developing an emphatic relationship around understanding and validating cultural experiences, (b) teaching Nguzo Saba principles to help with learning culture, and (c) engaging with community and using Traditional African dance rituals and movement with rhythm beats to promote mindfulness and present-centered awareness.

The elements can be applied by a three-step approach: (a) learning each Nguzo Saba principle, (b) learning to apply principles to improve cultural awareness and identity, and (c) practicing each principle with African movement and music in session. Delivered by culturally competent providers, the intervention is using a culturally adapted program of community connection and healing to encourage empowerment and engagement. This new culturally adapted intervention for trauma, depression, and anxiety based on Nguzo Saba principles and African dance movement has the potential to address the important lack of culturally specific psychological interventions. Future research and clinical implications of the SCT model can be used within a group setting. The stages of the SCT model are outlined in the following sections.

Administering SCT

Initial Session

The goal of this session is to set the stage clinically.

1. Provider assesses the client's background and current referral question for treatment in PTSD, depression, and/or anxiety.
2. Provider assesses areas of concern by administering self-report questionnaires of PCL-5 Monthly, PCL-5 Weekly, PHQ-9, and GAD-7 as a screening tool for meeting diagnostic criteria.
3. If client meets criteria for PTSD, depression and/or anxiety, then clinician describes the introduction of SCT.

4. Once a client agrees to participate in SCT, the clinician and client sign a therapy contract as a helpful agreement to understand each other's roles.

Session 1

1. Clinician guides the client on the beginning of psychoeducation and utilization of the Nguzo Saba first principle of *umoja* (unity). Clinician describes umoja as the African ethical understanding of being *of* and *with* each other as a way to cultivate a positive sense of oneness with themselves, as well as to each other, members of the African diaspora, their community, and the world.
2. Clinician discusses how umoja can maintain unity within one's race and culture by standing and advocating in solidarity with the perpetual cycle of oppression and suffering by creating a personal obligation to care for the environment and others.
3. At the end of the session, the clinician and client discover options for the week to practice unity with others in their family, community, or strangers to help develop peacefulness within the community as a coping skill. Some options may include creating heartfelt dialogue/conversations with family members, telling family members that they are loved and why, researching family tree, volunteering to help beautify the neighborhood, helping a senior family member with tasks, taking part in a protest, or joining with others in calling legislators for the act of police brutality.

Session 2

1. Clinician and client review the homework assignment from the first session.
2. Clinician guides client on the psychoeducation and utilization of the Nguzo Saba second principle of *kujichagulia* (self-determination). Clinician describes kujichagulia as the act

of defining oneself, naming oneself, speaking for oneself as a member of the African diaspora, and defending oneself instead of allowing others to shape or define oneself.

3. Clinician describes the Black racial identity developmental model by William Cross, and assists client with identifying which stage they are in.
4. This session affirms, rescues, and reconstructs the cycle of oppression. This session also discusses the beginning of recovering lost African cultural memories, accepting historical and cultural identity versus fitting into another culture and to speak their own truth to the world.
5. At the end of the session, the clinician and client discover practice "homework" options for the week to help create deep-rooted respect for their identity and reveal their own culture in a way to preserve the ways of their ancestors as a mindfulness and positive coping skill for areas of discrimination or racial trauma causing anxiety and depression symptoms. Some options may include researching the African cultural values and how it can be applied to their lives, learning about a historical figure, event, or organization of the Pan-African diaspora, researching individuals in the community that works positively as a group, identifying what values best define them, or writing prompts such as "Who am I?" "Am I really who I say I am?" "Am I all that I ought to be?" and "What does it mean to identify as member of the African diaspora?"

Session 3

1. Clinician and client review the homework assignment from the second session.
2. Clinician guides client on the psychoeducation and utilization of the Nguzo Saba third principle of *ujima* (collective work and responsibility). Clinician describes how ujima encourages and supports people to build a strong family of togetherness, community, and

the just society that they deserve to live in and to solve problems together. This session can help encourage the client, as well as inform them of how they can contribute to the Black family, community, and organizations that help support members of the African diaspora.

3. At the end of the session, the clinician and client discover and practice "homework" options for the week that to help solve problems of poverty, homelessness, police-related deaths, and the future of Black humanity. Some options may include working on projects at home with loved ones, helping the elderly with groceries, volunteering in doing positive things in the community, and journaling prompts of identifying how their family helps impact for their overall well-being.

Session 4

1. Client completes the PCL-5 Monthly, GAD-7, and PHQ-9.
2. Clinician and client review the homework assignment from the third session.
3. Clinician guides client on the psychoeducation and utilization of the Nguzo Saba fourth principle of *ujamaa* (cooperative economics). Clinician describes how Ujamaa is a principle of shared work and wealth within the Black community.
4. This session focuses on the commitment to help build, manage, connect, and maintain Black-owned stores, shops, and business while helping to profit together.
5. At the end of the session, the clinician and client discover and practice "homework" options for the week to help build a connection within the Black community and develop ways to help the Black community thrive with behavioral activation. Some options may include supporting, investing, and buying from Black-owned business, utilizing and promoting the use of Black-owned Banks, creating wealth and money ventures with

family, and journaling (reflection) prompts of the material discussed. These prompts could include, “What are some ways I can contribute to my local community?” and “How can supporting Black businesses bring the community together?”

Session 5

1. Clinician and client review the homework assignment from the fourth session.
2. Clinician guides client on the psychoeducation and utilization of the Nguzo Saba fifth principle of *nia* (purpose). Clinician describes how Nia is a principle of personal purpose that is complementary to social purpose.
3. This session focuses on the self-identity and recognizing how their true purpose in life is beneficial for the empowerment, and restoration for the Black community. Teaching the African culture value of collectivistic and cultural-/community-based advancement principles with individualistic and self-gain advancement principles allows for the motivation to continue to the path of past great leaders who influenced, inspired, and invoked commitment of service that offers social value.
4. At the end of the session, the clinician and client discover and practice “homework” options for the week to help build meaningful purpose of themselves and others helping to restore the Black community to traditional greatness through developing a sense of purpose and limiting feelings of worthlessness. Some options may include searching and identifying purpose in life outside of career, books, and movies about cultural history, using art as an expression of positive community ideals, helping with community projects, participating in protests, helping create food or blood donation drives, creating book clubs, delivering care to others, and journaling (reflection) prompts of the material discussed.

These prompts could include, “How do I define my sense of purpose?” and “In what ways can my sense of purpose help influence and inspire the Black community?”

Session 6

1. Clinician and client review the homework assignment from the fifth session.
2. Clinician guidees client on the psychoeducation and utilization of the Nguzo Saba sixth principle of *kuumba* (creativity). Clinician describes that kuumba is a principle of the responsibility to always do as much as possible the community and influence a better world and environment by being in it.
3. This session focuses on the commitment to help heal and limit the effects of social injustice, police brutality, discrimination, oppression, and continued suffering by being the example. This session can also help the client develop a sense of purpose and identity by engaging in pleasurable activities that contributes to the community to help heal and uplift the community.
4. At the end of the session, the clinician and client discover and practice “homework” options for the week to help leave the community more beautiful and meaningful than how they have inherited it. Some options may include creativity of ground-breaking inventions/ideas for the community, painting a mural, starting a garden, writing a poem or song that expresses positive community ideals, supporting local artists, and journaling (reflection) prompts of the material discussed, such as “How can my creative actions impact my local community?” and “What hobbies or pleasurable activities that I enjoy can contribute the wellbeing and hope within the community?”

Session 7

1. Clinician and client review the homework assignment from the sixth session.

2. Clinician guides client on the psychoeducation and utilization of the Nguzo Saba seventh[h] principle of *imani* (faith). Clinician describes imani as a principle of faith in ancient ethical and spiritual teaching of ancestors where the journey of struggles and oppression can still end in doing good in the world for others.
3. This session is the most important to help guide the way of the other principles such as faith in the community, faith in oneself and one's family, and faith in one's purpose. It will also focus on the daily incorporation of hope despite the despair, racial trauma, and evil within the world by recognizing and believing in the good in the world. This session enables clients to believe that hard work and devotion of loving and kindness will work in their favor and that the suffering and oppression of people can be liberated.
4. At the end of the session, the clinician and client discover and practice "homework" options for the week to enhance hope of people and the righteousness and victory of their struggles. Some options may include connecting with a spiritual or religious practice, letting go and trusting oneself more, telling family members that they are loved and why, learning inspiring quotes or religious texts, and journaling (reflection) prompts of the material discussed, such as "How can my faith help develop my sense of identity?" and "How does my faith impact my family relationships, community, and my view of the world?"

Session 8

1. Client completes the PCL-5 Monthly, PHQ-9, and GAD-7.
2. Clinician and client review the homework assignment from the seventh session.
3. Clinician and client discuss the feedback and reflections of all seven principles.

4. Clinician guides client on the psychoeducation and utilization of African dance rituals and how it connects emotions, values, and sense of identity with ancestors and the Black community. Clinician describes how movement/dance can help decrease trauma symptoms as a way similar to mindfulness and exercise.
5. Clinician teaches and applies a traditional dance/movement intervention with drumming music either guided by the clinician, or taped video instruction as a way of coping and celebrating the client's knowledge, participation, and healing of the seven Nguzo Saba principles.
6. At the end of the session, the clinician and client discover and practice "homework" options for the week to instill coping skills. Some options may include a weekly gratitude journal, continued movement of dance rituals learned or meditation practices at home, and reflection of the emotions, feelings, and thoughts during the first dance session.

Session 9

1. Clinician and client review the homework assignment from the eighth session.
2. Clinician reviews with client the continued psychoeducation and utilization of African Dance rituals and how it connects emotions, values, and sense of identity with ancestors and the Black community. Clinician decribes how movement/dance can help decrease depression symptoms as a way similar to mindfulness and exercise.
3. Clinician teaches and applies a traditional dance/movement intervention with drumming music either guided by the clinician, or taped video as away of coping and celebrating the client's knowledge, participation, and healing of the seven Nguzo Saba principles.
4. At the end of the session, the clinician and client discover and practice "homework" options for the week that will help instill coping skills. Some options may include a

weekly gratitude journal, continued movement of dance rituals learned or meditation practices at home, and reflection of the emotions, feelings, and thoughts during the second dance session.

Session 10

1. Clinician and client review the homework assignment from the ninth session.
2. Clinician discusses the continued psychoeducation and utilization of African dance rituals and how it connects emotions, values, and sense of identity with ancestors and the Black community.
3. Clinician describes how movement/dance can help decrease anxiety symptoms as a way similar to mindfulness and exercise.
4. Clinician teaches and applies a traditional dance/movement intervention with drumming music either guided by the clinician, or taped video instruction during this session as way of coping and celebrating the client's knowledge, participation, and healing of the seven Nguzo Saba principles.
5. At the end of the session, the clinician and client will discover and practice "homework" options for the week to help instill coping skills. Some options may include a weekly gratitude journal, continued movement of dance rituals learned or meditation practices at home, and reflection of the client's emotions, feelings, and thoughts during the third dance session.

Session 11

1. In the final SCT session, client completes the PCL-5 Monthly, GAD-7, and PHQ-9.
2. Clinician and client review the homework assignment from the tenth session.

3. Clinician reviews with client the feedback and reflection of the last 10 weeks regarding the Nguzo Saba principles and the African dance rituals.
4. At the end of the session, the clinician and client review the self-reports completed and discuss any future direction necessary.

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APPENDIX A: THEORETICAL FRAMEWORK