Journal of Anxiety & Depression

Yumed Text
OPEN ACCESS JOURNALS

Review | Vol 7 Iss 2
ISSN: 2582-3264
https://dx.doi.org/10.46527/2582-3264.164

Mental Health Disparities among African American Young Adults

Zuri Muhammad and Shanika Lavi Wilson*

Department of social work, North Carolina Central University, USA

***Corresponding author:** Shanika Lavi Wilson, Department of Social Work, North Carolina Central University, USA, Tel: 919-423-7952; E-mail: swils108@nccu.edu

Received: May 25, 2024; **Accepted:** July 30, 2024; **Published:** August 15, 2024

Abstract

In America, African Americans often do not seek treatment for their mental illness. The lack of mental health service utilization is known as mental health disparities. The focus of the capstone was on mental health disparities among African American adults aged 18-25. Mental health disparities are caused by stigma, racism, and discrimination. The Affordable Care Act, House Bill 76, and WHO Special Initiative for Mental Health (2019-2023): Universal Health Coverage (UHC) were policies to address mental health disparities. The interventions discussed to solve this social problem are NTU Psychotherapy, Sawboana Healing Circles, and Oh Happy Day Class. A solution used to solve mental health disparities among this group is for practitioners to incorporate Sawboana Healing Circles when working with African American young adults.

Keywords: ***Mental illness; Affordable Care Act; African Americans; NTU psychotherapy***

1. Introduction

Mental health disparities disproportionately affect underrepresented groups, especially African American adults. Mental health disparities stem from historical racism, oppression, and stigma [1]. The purpose of the capstone is to examine the different areas of social problems and examine solutions. African American adults aged 18-25 were chosen because their mental illness is often overlooked and inadequately addressed, and cultural difference is not considered. Mental illness not being addressed among this group can lead to prolonged, chronic, and severe daily depression, disability, unemployment, substance abuse, homelessness, incarceration, and poor quality of life [2]. Solutions to this problem include implementing culturally sensitive interventions by practitioners utilizing these interventions for this population. The implication is that African Americans would be inclined to seek help and provide clinicians with a way to incorporate their cultural competence.

2. Scope of the Problem

Mental health disparity is defined as the lack of utilization of mental health services and interventions [3]. African Americans are disproportionally behind their white counterparts in the mental health care system [3]. 21.4% of African Americans have a mental illness, but 39.4% of African Americans receive treatment. Four and six percent of Black young adults have a severe mental illness, and 8.5% have serious suicidal ideation [4]. However, 58.2% of young adults do not receive treatment compared to 52.4% of White people receiving treatment [4]. When African Americans do seek treatment, they will not receive the same degree of care compared to white people. African Americans are mostly given inpatient resources over any other form of treatment and primarily will see general health care providers over specialists. In prisons and jails, 63% of individuals who are incarcerated in state and federal prisons do not receive treatment for their mental illness [4]. In the year 2017, 33% of inmates (federal and state prisons) were Black Americans, while 30% of inmates were White Americans [5]. African Americans make up many individuals in prisons and jails, so this means that this population (in prisons and jails) mainly does not utilize mental health services. African Americans who have a low socioeconomic status experience poverty, low income, and poor housing, which causes a person to more than likely experience mental health disparities. Black people who have a low socioeconomic status experience mental health disparity because they have barriers to utilizing these services. One of these barriers is being uninsured, which makes them less likely to be able to afford services and/or they will not be able to afford the proper mental care that they need [6]. As a result, this leads them not to utilize services. The uninsured are African Americans aged eighteen and up, so this means this age group experiences mental health disparities. On a federal level. 10.9% are uninsured, whereas, in North Carolina (N.C.), 21.9% are uninsured. Federally, Black Americans have an uninsured rate of 10.0% [7]. In NC, 11% of African Americans are insured compared to 9.6% of white people. In Durham County, 10% of Black people are uninsured [8].

3. The Problem of Mental Health Disparity

Mental health disparities can occur at any stage in life. However, African Americans living in rural communities have a higher chance of mental health disparities because, in these areas, mental health services are not accessible, available, or affordable, and it is hard to reach out for services [9]. In rural areas, lack of treatment affects Black Americans [9,10]. People in rural communities must travel to other places to receive treatment. Around 60% of people who live in rural areas live in places that have mental health provider shortages, and about 65% of rural Americans do not have a psychiatrist [11]. Black people also cannot get their needs met because they cannot afford it. James et al. found that 24.5% of Black Americans could not seek treatment because they could not afford it. Mental health disparities among this group are attributed to historical racism, discrimination, personal and community stigma, and being uninsured [1]. White medical practitioners were taught and believed that African Americans had a higher pain tolerance [12], so their problems were overlooked or unaddressed. African American communities also have a stigma and provider bias, which creates a barrier for African Americans to go out and seek mental health services. A provider holding certain beliefs leads to dismissing or overlooking feelings and symptoms, which causes improper treatment or discourages people from seeking treatment because they feel their concerns will not be taken seriously [13]. Mental illness in the African American community has a negative connotation, so people do not seek treatment because of the fear of being ridiculed or outcasted from their community.

4. Population

African Americans aged 18-25 are the focus group because there is a plethora of evidence showing that mental health disparities affect this group [1,4]. This age range experiences the most significant amounts of mental health problems, and the rate at which they seek mental health services is low. A couple of questions arise: Is there anything that providers are not doing that contributes to the disparity? Is there anything that providers are doing that decreases the disparity?

5. Cultural Competence

African Americans tend to go to primary healthcare professionals more than specialists for their mental health needs, so the knowledge that the professionals have affects the services they provide. Shepherd et al. examined healthcare professionals' knowledge and experience around different aspects of cultural competence [15]. Healthcare professionals (n =56) completed a 19-item questionnaire about their cultural competence, working with diverse clients, and their perspectives on culturally competent care. They found that healthcare providers believed that they knew, but they did not take any classes in diversity. The study looked at the healthcare profession, so a disadvantage is that the cultural competence of each healthcare profession is not examined.

Unlike the Shepherd et al. study, the McElory et al. cross-sectional descriptive study focused solely on nurses [15,16]. McElroy et al. found that the information nurses were taught was a stepping stone to cultural competence [16]. The study aimed to examine nurses' knowledge of aspects of cultural competence. McElroy et al. had the participants (registered nurses, nursing assistants, and clinical support technicians) take a modified culture awareness scale (CAS) version [16]. The results showed that many of the participants had cultural awareness. If the McElroy et al. study was expanded to test culture awareness through client interactions, then the study could better understand what the nurses know [16].

The question of whether nurses have cultural competence extends to various types of nursing fields. In a research article by Alpers and Hanssen, psychiatric nurses and medical nurses self-tested their cultural awareness [17]. The study examined nurses' cultural competence, like McElroy et al. (2016) [16]. However, Alpers and Hanssen tested cultural competence within nurses' interactions with clients [17]. At the beginning of the study, the researchers conducted three focus interviews. Following the interviews, 245 nurses submitted a questionnaire. The results of the study showed that both types of nurses lacked cultural competence when it came to mental illness and treatment for a diverse population. The study was done as a self-assessment, which means there is a chance that the participants were not truthful on the assessment.

The cultural competence within the relationship between practitioner and client is further investigated in the Benulto et al. mixed method study. Contrary to the Alpers and Hanssen (2014) research and the McElroy et al. study, Benulto et al. examined cultural competence in a clinical setting [18]. The study examined culturally sensitive practices that clinical professionals used with clients, clinicians who used culturally sensitive practices, and how culture is factored in with their treatments. Nine clinicians were in the first study, and 142 were in the second. In the first study, the clinicians participated in an interview, while those in study two did a survey. Benulto et al. found that clinicians could deliver culturally sensitive services, tailor interventions and treatment to their clients, and use culturally sensitive methods [18]. Indeed, the research shows a pattern of literature focusing on whether practitioners have cultural competence.

6. Anti-oppression

Unlike the Shepherd et al., McElroy et al., Alpers and Hanssen, and Benulto et al. studies. The Wu et al. study examined a specific type of cultural competence [19]. Wu et al. examined the effectiveness of health professionals learning about anti-oppression from an anti-oppression framework perspective [19]. The results showed that 486 professionals are better equipped to address bias by allyship—the curriculum equipped professionals with social justice, equality, and equality.

Like the Wu et al. study, Punchhi et al. looked at healthcare professionals learning about anti-oppression, but the researcher focused on medical professionals [20]. Punchhi et al. conducted interviews with 19 medical professionals [20]. The study results showed that medical education does not align with anti-oppression education, so anti-oppression education is only partially effective. However, education is effective for some medical professionals because of their experience with oppression. The Wu et al. study and the Punchhi et al. study are limited in focusing on anti-oppression in the public health domain [19,20]. Studies show that research on this topic primarily focuses on the public health domain. As a result, there is limited research on antioppression in the mental health domain, so the results might not be generalizable to all the helping professions.

7. Anti-racism

Like the Wu et al. study, Vega et al. researched a specific type of cultural competence, but Vega et al. also looked at anti-racist education [21]. Vega et al. examined how an education on anti-racism in school would affect future practitioners. In the mixed method study, students in a psychology class took a multicultural course covering empathy and sensitivity towards people of different ethnicities and races [21]. Vega et al. found a difference between people of color and white students' understanding of ethnic identity, but empathy and sensitivity toward people of different ethnicities and races increased [21]. In addition, the class made the students feel that they would be future practitioners who value creating a safe space and learning environment and would have increased cultural awareness. The limitation of this study is that it focuses on future practitioners, so the disadvantage is not knowing how antiracism education affects practitioners already in the field.

Like the Vega et al. study, the Lenes et al. randomized control study looked at anti-racism among practitioners [22]. However, they examined both future practitioners and practitioners in the field. Lenes et al. gave 39 pre-licensed counselors and counselor students The Color-Conscious Multicultural Mindfulness (CCMM) training [22]. The results showed that engaging in the training that practitioners and future practitioners increased their multicultural competence and reduced their color-blind attitudes around concepts of privilege, institutional racism, and explicit racism.

8. Culturally Tailored Treatment/Interventions

The research thus far has examined whether practitioners have cultural competence.

However, culturally sensitive, tailored intentions must be addressed to grasp how practitioners' knowledge affects clients. A practitioner's knowledge can be used to provide better support to the African American population. In addition, knowledge about cultural competence can lead to the creation of new tools to deliver services.

9. African Americans

The literature on culturally tailored interventions for African Americans is slim to none.

On the other hand, the interventions for African Americans tend to focus on depression. The Calmer Life program (a cognitive behavioral treatment) was found to be an effective intervention for African Americans who were 50 and up [23]. Stanley et al. examined the effectiveness of the Calmer Life program and Enhanced Community Care for African Americans who have depression or anxiety. Participants (n= 40) either did the Calmer Life intervention or received Enhanced Community Care [23]. The results showed that Calmer Life made more of an improvement in participants' depression and anxiety than Enhanced Community Care. The limitation of this study is that the researchers focused their examination on a small geographical area, so the generalizability of this study is in question.

Similar findings were found in the Ward et al. study. Ward et al. conducted a study on African Americans [24]. They compared the cognitive behavioral group (intervention)Oh Happy Day Class (OHDC) and the Coping with Depression Course (CWD) to test the effectiveness of the interventions. Participants (n = 132) were randomly assigned to OHDC or CWD to treat their depression [24]. Ward et al. found that both interventions were successful in reducing depression for the participants, but OHDC was better at reducing depression for African

10. American Adults

The previous research makes it apparent that culturally tailored mental health interventions for African Americans are not abundant. On the other hand, culturally tailored interventions are effective at reducing mental health symptoms. In addition, depression interventions tailored for African Americans are mainly concentrated on cognitive behavioral treatments.

Based on past research, culturally tailored mental health interventions are successful at reducing mental health symptoms, but the interventions for African Americans are scarce and limited. Additionally, the literature only discusses whether a practitioner has cultural competence. In other words, literature does not discuss ways cultural competence could create solutions. If practitioners do not implement culturally tailored interventions, the social problem will not be resolved. African Americans will not utilize services, and/or traditional mental services will continue to be ineffective for this group. The gap will be addressed by implementing more diverse culturally sensitive interventions for African Americans to address health disparities. The increase in culturally tailored intervention will make it more likely for African Americans to want to receive treatment for their mental illness.

11. Theatrical Frameworks and Mental Health Disparity

The mental health field has created numerous theories to address mental health symptolmalogy. Theories explain why and what causes a person to behave in a specific manner and how behaviors form. The Health Belief Model (HBM) should be used to address mental healht disparities. The Health Belief Model (HBM) was conceptualized by many social psychologists during the 1950s and 1960s, with Rosenstock being one of the key contributors. This theory was created because psychologists wanted to know why people were not getting health screenings [25]. Rosenstock assumed that an individual's decision to partake in preventive health screenings and health detections depends on their perception of the disease's severity and susceptibility [26].

The HBM comprises six constructs that can predict behavior: perceived risk susceptibility, perceived risk severity, benefits of action, self-efficacy, and cues to action. According to Rosenstock's theory, a person will seek health screenings and detection if they believe the risk is severe and the benefits outweigh the perceived risks. Over time, the theoretical framework has expanded to encompass various physical and non-physical health behaviors.

Despite the original assumption, researchers took the basis of the model to apply it to other health areas, such as mental health. In the context of mental health, the model can explain whether a person seeks mental health services. HMB provides insight into potential solutions for providing access to mental health services to African Americans. A possible solution could be to increase African Americans' mental health service utilization by applying the theory to address their perception.

HBM has a plethora of empirical data on the use of mental health services. Lily et al. used HBM to examine mental health seeking for college students with depression [27]. The results of the study showed that college students are more likely to seek depression services if they perceive that severity, self-efficacy, and cue-to-cue actions are high. However, a college student does not seek depression services if they perceive that seeking services will have barriers or benefits. Like the study by Lily et al. (2020), Nobiling and Maykrantz (2017) examined college students, but they focused on mental health seeking in general. The study found that college students perceived difficulty figuring out the system, and socio-cultural concerns were barriers. In addition, HBM has been used to look at help-seeking among minority racial groups [28]. Kim and Zane studied and compared mental health service seeking among Asian Americans and White Americans [29]. Kim and Zane concluded that Asian Americans had severe mental health challenges, but they were less likely to have the intention of seeking out mental health services [29]. The reason that Asian Americans did not utilize treatments is that they perceived that there were not many benefits in using mental health services and that they had many barriers to treatment.

The strengths of HBM are that it seeks help on an individual level and all the constructs connect. However, the theory does not consider habitual behaviors or behaviors done for non-health reasons or account for environmental or economic factors [25]. HBM can be applied to come up with a solution that will change their perceptions and make them want to seek mental treatment. In addition, HBM will be applied to existing policy, practice, and research by examining how the policy and practice would affect if it would make them more likely to receive treatment based on their perception.

12. Cultrualy Sensitive Interventions for Mental Health Disparities

Urie Bronfenbrenner developed the ecological systems theory in the 70s. Bronfrenbrenner’s work was shaped by witnessing children facing hardship in Russia due to social change (Guy-Evans, 2024). According to Bronfenbrenner (1979), people interact with different environments (systems) that influence their behavior. The theory comprises five systems: the microsystem, mesosystem, exosystem, macrosystem, and chronosystem. The microsystem is the direct environment. The mesosystem is the relationship between a person’s microsystem. The exosystem is a system that does not directly affect a person but still affects the person. The macrosystem is the person's customs, religion, etc. The chronosystem is the changes during the life span.

13. NTU Psychotherapy

NTU is an Afrocentric spiritual-based intervention that strives to help clients be conscious of their spirit, increase their awareness, realign themselves (with the seven principles), and utilize their increased knowledge [30]. The basic principles are harmony, balance, interconnectedness, cultural awareness, and authenticity [30]. NTU emphasizes that the healing process is a natural process within the self. The five phases are harmony awareness, alignment, actualization, and synthesis. In NTU, the therapist's role is to facilitate the client's alignment of their mentality, spirituality, and physicality [30]. Opppong et al. (2019) looked at the effectiveness of NTU on trauma for refugees in Ghana [31]. The results of the study showed that NTU helped to improve a person's trauma. The limitation of the study is that it only focused on one specific group. However, the intervention could be examined in multiple aspects due to the within-subject design. Culturally sensitive interventions work better for African American young adults and practitioners have cultural competence.

14. Sawubona Healing Circles

Sawubona Healing Circle (SHS) is a newer, culturally sensitive rapid response program created by the Association of Black Psychologists (ABPsi). The intervention focuses on healing using African-centered worldviews and healing methods to help African Americans feel empowered and self-heal through learning about wellness strategies [32]. In SHS, the circle members share their thoughts, feelings, and reactions to racial trauma. Aguste et al. focused on the effectiveness of the sawbones healing circle [32]. The results show that this intervention is effective for African Americans. The study had a large amount of data, so there was high validity, but it did not address the feasibility, acceptability, and effectiveness of this intervention for mental health [33]. Morales et al. used the intervention of healing circles for the undocumented community. The results showed that the healing circle increased undocumented immigrant's knowledge and resilience. The study did not focus on mental health or African Americans. However, it showed that the healing circle is versatile in being an effective intervention and incorporating aspects of culture. Practitioners should incorporate and use the Sawboanna healing circles in their practice to treat depression among African American young adults. The healing circle can be a way for practitioners to practice their cultural competence and increase mental health seeking among this population. African Americans tend not to see professionals for mental health, so the healing circle can be utilized by any practitioner [32].

15. Oh Happy Day Class

Oh Happy Day Class (OHDC) is a 12-week culturally adapted intervention. OHDC was adapted from the coping with depression intervention (CWD), and it utilizes cognitive behavioral therapy and psychoeducation to learn about depression, treatment options, healthy coping skills, and changing negative attitudes [24]. Ward et al. conducted a pilot study on the efficacy of OHDC on depressed African American adults by comparing it with CWD [24]. The two interventions were found to be effective, but OHDC was more effective at treating depression. The study design allowed for an in-depth comparison of how OHDC is effective. However, the full scope of the invention was not examined because the study compared two interventions. William et al. examined OHDC for African American cancer survivors [34]. The results showed that this intervention is acceptable to use with this population, but the effectiveness of the intervention on this population is still unknown [34]. The study showed that OHDC can be used for different groups within the African American population. In context to the Health Belief Model, the perceived benefits of the intervention being culturally sensitive would outweigh the risks of the treatment,

so a person will want to seek help. Therefore OHDC could be an effective evidenced based treatment option for African Americans with symptoms of a mental health disorder.

16. Discussion and Conclusion

The existing research has shown that culturally tailored interventions are more effective than traditional mental health interventions for treating mental health problems. Practitioners have the knowledge and skills to work with individuals of different cultures but are not utilizing their competencies. As a result, this further hinders African American young adults from wanting to seek services. The solutions to this social problem are NTU Psychotherapy, Sawubona Healing Circles, and Oh Happy Day Class. These interventions will address mental health disparities for this population because these solutions are culturally sensitive, and research shows that these interventions are effective for this population. HBM theory's basis of help-seeking was used to determine the strengths and limitations of the policies and practices. The limitations are based on whether the policy or practice prevents a person from seeking help for their mental health. In the context of HBM, a person believes their problem is not severe and/or the benefits do not outweigh the risks [26]. The strengths are based on whether the policy or practice increases the likelihood that a person will seek help for their mental health. In the context of HBM, the person believes that their problem is severe and/or the benefits outweigh the risks [26].

The innovative solution is for practitioners to utilize Sawboana healing circles in their practice when treating mental health problems, especially depression, for this population. Practitioners should receive training to utilize this type of intervention. The innovative solution closes the gap in the literature of practitioners having cultural competence but not using the knowledge. This intervention allows practitioners to practice their cultural competence.

Additionally, the innovative solutions address the gap of limited cultural interventions by adding more diverse culturally sensitive interventions for the African American population. In a policy context, the innovative solution affects organizational policies and practitioners' service policies. Sawoanna Healing Circle is a service that practitioners will utilize, affecting policy information regarding services provided by practitioners. The policies on the types of services practitioners can provide may need to be changed or amended based on practitioners providing this service. The broader policy implications are reexamining the insurance policies for practitioners to include liability for these services and the federal healthcare policies (if applicable) to include coverage for spiritual-based treatments. In the context of practice, practitioners utilizing the healing circles means that the practice of mental health treatment would expand to encompass culturally sensitive treatments. Traditional interventions would not be the only options for treatment, and culturally tailored interventions would be more widespread throughout practice. The practice implication is that practitioners will create more treatments to best-fit individuals who have cultures different than the dominant group, and a lot more services will be provided for the African American young adult population. Practice informs research, so the research implication would be that more studies will focus on spiritually-based intervention, and more people will be aware and know about this intervention. The solution is effective because it encourages people to seek help, decreasing the disparity. According to HBM, the benefit of the intervention for this population outweighs the perceived risk of the treatment, so this population will seek treatment because the intervention is designed for this population. Thus, the mental health disparity decreases.

REFERENCES

1. Bommersbach TJ, Rhee TG, Stefanovics EA, et al. Comparison of black and white individuals who report diagnoses of schizophrenia in a national sample of U.S. Adults: Discrimination and service use. Schizophr Res. 2023;253:22-9.
2. Bailey RK, Mokonogho J, Kumar, A. Racial and ethnic difference: Current perspectives. Neuropsychiatr Dis Treat. 2019;15:603-9.
3. Juda E. Racial disparities in mental health treatment. SC-UMT. 2021. https://online.simmons.edu/blog/racial-disparities-in-mental healthtreatment/#:~:text=Mental%20health%20disparity%20refers%20to,%2C%20age%2C%20and%20symptom%20expression.
4. National Association of Mental Health (NAMI). Mental health by the number. 2023. https://www.nami.org/mhstats
5. Geller J. Structural racism in American Psychiatry and APA: Part 8. Psychiatric News. 2020;55(20).
6. Han B, Gfroerer J, Kuramoto SJ, et al. Medicaid expansion under the Affordable Care Act: Potential changes in receipt of mental health treatment among low-income nonelderly adults with serious mental illness. Am J Public Health. 2015;105(10):1982-9.
7. Artiga S, Hill L, Damico A. Health coverage by race and ethnicity. 2010-2021. Kaiser Family Foundation. 2022. https://www.kff.org/racial-equity-and-health-policy/issue-brief/healthcoverage-by-race-and-ethnicity/
8. Durham County Community Health Assessment. 2021. https://healthydurham.org/cms/wpcontent/uploads/2022/09/2021-Durham-SOTCH-Report.pdf
9. Rural mental health overview. Rural Health Information Hub (RHIU). 2023. https://www.ruralhealthinfo.org/topics/mental-health
10. Moyce S, Thompson S, Metcalf M, et al. Rural Hispanic perceptions of Mental Health: A qualitative study. J Transcult Nurs. 2022;33(3):346-54.
11. Morales DA, Barksdale CL, Beckel-Mitchner AC. A call to action to address rural mental health disparities. J Clinand Transl Sci. 2020;4(5):463-7.
12. Hammonds EM, Reverby SM. Toward a historically informed analysis of racial health disparities since 1619. Am J Public Health. 2019;109(10):1348-9.
13. Merino Y, Adams L, Hall WJ. Implicit bias and mental health professionals: Priorities and directions for research. Psychiatric Serv. 2018;69(6):723-5.
14. Vance TA. Addressing mental health in the Black Community. Columbia University Department of Psychiatry. 2019. https://www.columbiapsychiatry.org/news/addressingmental-health-black-community
15. Shepherd SM, Willis-Esqueda C, Newton D, et al. The challenge of cultural competence in the workplace: Perspectives of healthcare providers. BMC Health Serv Res. 2019;19(1):135.
16. McElroy J, Smith-Miller CA, Madigan CK, et al. Cultural awareness among nursing staff at an academic medical center. JONA: J Nurs Adm. 2016;46(3):146-53.
17. Alpers LM, Hanssen I. Caring for ethnic minority patients: A mixed method study of nurses' cultural competency self-assessment. Nurse Educ Today. 2014;34(6):999-1004.
18. Benuto LT, Newlands R, Singer J, et al. Culturally sensitive clinical practices: A mixed methods study. Psychol Serv. 2021;18(4):632-42.
19. Wu D, Saint-Hilaire L, Pineda A, et al. The efficacy of an anti-oppression curriculum for health professionals. Family Med. 2019;51(1):22-30.

20. Punchhi G, Shum K, Sukhera J. Anti‐oppressive pedagogy in Medical Education: Racism in Medicine and Healthcare. (2022). University of Arizona. 2023. https://libguides.library.arizona.edu/racism-medicine/mental-health\
21. Vega D, Tabbah R, Monserrate M. Multicultural School Psychology Training: An examination of students' self‐reported course outcomes. Psychology in the Schools. 2018;55(5):449-63.
22. Lenes E, Swank JM, Hart KA, et al. Color‐conscious multicultural mindfulness training in the counseling field. J Couns Dev. 2020;98(2):147-58.
23. Stanley MA, Wilson N, Shrestha S, et al. Calmer life: A culturally tailored intervention for anxiety in underserved older adults. Am J Geriatr Psychiatry. 2016;24(8):648-58.
24. Ward EC, Brown RL, Sullivan-Wade L, et al. Culturally adapted depression intervention for African American adults: An efficacy trial. Wisconsin Med J. 2021;120(4):273-80.
25. LaMorte W. Behavioral change models. The Health Belief Model. 2022. https://sphweb.bumc.bu.edu/otlt/mphmodules/sb/behavioralchangetheories/behavioralchangetheories2.
26. Rosenstock IM. Why people use health services. Milbank Q. 1966;44:94-127.
27. Lilly FRW, Jun HJ, Alvarez P, et al. Pathways from health beliefs to treatment utilization for severe depression. Brain Behav. 2020;10(12):e01873.
28. Nobiling BD, Maykrantz SA. Exploring perceptions about and behaviors related to mental illness and mental health service utilization among college students using the Health Belief Model (HBM). Am J Health Educ. 2017;48(5):306-19.
29. Kim JE, Zane N. Help-seeking intentions among Asian American and White American students in psychological distress: Application of the health belief model. Cultur Divers Ethnic Minor Psychol. 2016;22(3):311-21.
30. Phillips FB. NTU Psychotherapy: Personalism and the Bodymind. Ghana Int J Mental Health. 2018;6(7):1-32.
31. Oppong D. The effectiveness of NTU Afrocentric system of psychotherapy in the management of Trauma among refugees in Ghana. Afribary. 2021. https://afribary.com/works/the-effectiveness-ofntu-africentric-system-of-psychotherapy-in-the-management-of-trauma-among-refugees-inghana
32. Auguste E, Lodge T, Carrenard N, et al. Seeing One Another: The Creation of The Sawubona Healing Circles. 2022.
33. Morales FR, González Vera JM, Silva MA, et al. An exploratory study of healing circles as a strategy to facilitate resilience in an undocumented community. J Latinx Psychol. 2023;11(2):119-33.
34. Williams EA, Ward E, Wujcik D, et al. "Oh happy day": A pilot study of a culturally tailored depression intervention for African American female cancer survivors. Cancer Epidemiology, Biomarkers & Prevention, 23(11_Supplement). 2014.