

INTRODUCTION: COGNITIVE BEHAVIORAL MODELS, MEASURES, AND TREATMENTS IN ETHNORACIAL GROUPS

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As history has repeatedly shown, the complex process of science, like all human endeavors, changes as the values and visions of society change across time (Kuhn, 1962). Thus, it should not be surprising that systematic efforts to understand and treat psychological problems experienced by individuals have themselves changed considerably over the past century. In the modern era, one of the most dominant paradigms to emerge for understanding and treating psychological problems has been the cognitive behavioral paradigm.

THE RISE OF THE COGNITIVE BEHAVIORAL PARADIGM IN MODERN DAY PSYCHOLOGY

In historical context, the behavioral paradigm emerged in response and reaction to earlier psychoanalytic models that both pioneered and influenced the way mental health professionals treated psychological problems.

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Treating Depression, Anxiety, and Stress in Ethnic and Racial Groups: Cognitive Behavioral Approaches,
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In contrast to the use of highly subjective techniques like introspection, free association, and dream analysis, the initiation of behavioral therapies in the early to mid-1900s was founded on the principles of operant and classical conditioning, which posited the learning of overt behaviors through processes involving conditioning and reinforcement. Within the behavioral framework was the basic assumption that the causes of psychological disturbances were rooted in learning and the contexts that maintained those maladaptive behavior patterns.

However, by the 1970s, psychology, along with other disciplines (e.g., philosophy, neuroscience, anthropology, linguistics, computer science), experienced developments in what would later be known as the *cognitive revolution* (Miller, 2003), the result of a collective synergy among multidisciplinary efforts that emphasized the role of cognition and cognitive processes in how individuals engaged with their world (Robins, Gosling, & Craik, 1999). In many ways, this change represented a return to psychology's founding mission. Specifically, the scientific understanding of how the content and function of human consciousness defined human experience had been the original aim of the new "mind science" as conceptualized by its earliest pioneers (Downey & Henderson, 2017). Within psychology, the cognitive approach focused largely on the individual's cognitions, such as beliefs, attributions, expectations, or appraisals, and psychological problems were viewed as being caused by maladaptive thoughts and dysfunctional thought processes associated with the self, world, or future.

During this time, the behavioral and cognitive paradigms remained somewhat separate from each other. However, by the late 1970s, behaviorists and cognitive psychologists began to recognize a growing need to integrate these two conceptually disparate approaches to garner a richer and more meaningful understanding of human behavior. One substantive example of this recognition was the development of Bandura's (1977, 1986) triadic reciprocal determinism model that implicated the important and dynamic interplay between behavior, cognitions, and environment. Indeed, so compelling was the pressure to identify with the positive value of integrating behavioral and cognitive approaches that the Association for Advancement of Behavioral Therapies established in 1966 was later renamed in 2005 as the Association for Behavioral and Cognitive Therapies. Alternatively, theories and therapies that were once almost exclusively cognitive evolved to increasingly incorporate behavioral processes and principles, as evidenced by the rebranding of rational-emotive therapy (Ellis, 1962) to rational emotive behavior therapy 3 decades later (Ellis, 1995).

In turn, the emergence of integrative theories that examined the confluence of behavioral and cognitive factors on psychological problems helped give rise to treatments that pointed to targeting and changing both behavioral

and cognitive elements, namely, cognitive behavior therapies (for a comprehensive historical review, see Dobson & Dozois, 2010). Cognitive behavior therapies include a diverse set of therapeutic techniques whose common aim is to improve psychological functioning through the modification of beliefs, perceptions, knowledge, and/or emotional experience, as well as the behaviors that accompany them in mental health conditions. As cognitive behavioral theories were developed and tested in practice, they, in turn, fueled further refinements to help mental health professionals identify those strategies and techniques that were both high in efficacy and efficiency. So useful have cognitive behavioral approaches become in the treatment of a spectrum of psychological problems, that a large proportion of practitioners readily identify themselves as aligned with a cognitive behavioral orientation (Norcross & Rogan, 2013). Indeed, with extensive empirical support over the past several decades, cognitive behavioral models, measures, and treatments (CBMMTs) have been widely used to conceptualize, assess for, and treat commonly experienced psychological problems, including depression, anxiety, and stress. That said, however, the validity and utility of cognitive behavioral approaches for working with ethnoracially diverse populations, although promising, have gone largely unexamined (Hofmann, 2006; Iwamasa, 1996).

ON THE NEED TO INTEGRATE ETHNORACIAL FACTORS IN COGNITIVE BEHAVIORAL MODELS, MEASURES, AND TREATMENTS: REMINDING OURSELVES THAT SPECIFICITY ALWAYS MATTERS

Despite the well-established use of CBMMTs for treating psychological problems, we were deeply troubled by a dearth of CBMMTs targeted for use with diverse ethnoracial groups (e.g., Asian Americans, Latin Americans, African Americans, American Indians). We found this problematic for a number of reasons. First, Asian Americans, Latin Americans, African Americans, and American Indians represent approximately 40% of the current United States population, and according to projected rates for 2060 by the U.S. Census Bureau, these groups will make up more than half of the U.S. population (Colby & Ortman, 2015).

Second, sociocultural factors such as ethnoracial discrimination and acculturative stress pose different trajectories of risk for the development of psychological problems compared with risk factors affecting non-Hispanic Whites. As cognitive behavioral approaches were developed from within a Western cultural context and strongly predicated on European American values (Hall, Hong, Zane, & Meyer, 2011; Hays, 2009), it is likely that these

approaches may not be as useful for non-European American groups that adhere to other cultural values and visions.

Third, although ethnoracial disparities in mental health services have decreased over the years, findings from a meta-analysis of over 130 research studies and over 4 million clients found worrisome racial differences in mental health service use. For example, Asian Americans were just 51% as likely as White European Americans to use mental health resources. In addition, Hispanics/Latinos were only 25% as likely as Whites to use such resources, and African Americans were a mere 21% as likely to use mental health resources as Whites were (Smith & Trimble, 2016). Possible reasons for why this disparity prevails may include how many of the available empirically supported treatments, such as cognitive behavioral interventions, are not as effective for individuals from diverse ethnoracial groups. Also, the conceptualization of their experiences with mental health concerns is not effectively captured by the available traditional, nonculturally adapted cognitive behavioral models and assessment measures of psychological problems. Last, but not least, the dearth of CBMMTs for working with diverse ethnoracial groups is inconsistent with a central tenet underlying cognitive behavior therapy (CBT)—namely, the importance of appreciating the specifics of the complex clinical situation. This emphasis on clinical precision is not limited to an appreciation of the particulars of the presenting psychological problem (e.g., phenomenology, duration, severity) but also includes an appreciation of the particular characteristics embodied and brought forward by the client (e.g., race, culture, language, and socioeconomic background; Flaskerud, 1986; López, 1989). Yet, the inclusion of ethnoracial considerations has remained limited, if not disconnected, from the mainstream of CBMMTs (Cardemil, 2010), paralleling similar disparate patterns evidenced across areas in psychology and psychiatry (Chang, Downey, Hirsch, & Lin, 2016; Chang & Kwon, 2014).

OVERVIEW OF POPULATIONS OF FOCUS

It is important as we open this volume to share key factual details about each racial/ethnic group being discussed within so that the findings presented can be contextualized appropriately. Many of our contributing authors added their perspectives to these descriptions as noted.

Asian Americans

The 2010 United States Census revealed that between 2000 and 2010, the population of Asian Americans grew more quickly than any other racial group in the nation (Hoeffel, Rastogi, Kim, & Shahid, 2012). According to

the Census assessment, Asian Americans include any U.S. citizen of Chinese, Japanese, Korean, Filipino, Vietnamese, Cambodian, Thai, Asian Indian, Pakistani, Native Hawaiian, Guamanian or Chamorro, Samoan, or other Asian or Pacific Islander background. Clearly, this is an extremely diverse group of individuals, many of whom come from nations within East Asia, South Asia, and the Pacific Island regions, which have historically seen themselves as utterly distinct and sometimes even as enemies. These diverse cultures and histories make speaking about this group as monolithic a challenge and have crucial implications for mental health treatment (Abe-Kim et al., 2007). However, the American approach to racial classification typically overlooks such differences in determining the size, geographic distribution, and needs of these individuals across the country.

The census report on Asian Americans placed the official population of this group at 14.7 million in 2010, up from 10.2 million in 2000 (an increase of 43%). When counting individuals who listed Asian as among their racial group memberships, the total population was 17.3 million, 46% higher than 10 years prior, accounting for 5.6% of the total U.S. population (Hoeffel et al., 2012). By 2015, growth had accelerated again, as this group had grown to 20.4 million. Chinese (24%), Asian Indian (20%), and Filipino (19%) groups represent the largest proportions of Asian Americans by nationality (Pew Research Center, 2017). This explosive population growth was most apparent in the American West, with nearly half of all Asian Americans residing in this region (and about a third of all Asians residing in California alone; Hoeffel et al., 2012). Because this group is largely growing due to immigration rather than birth, the median age of Asian Americans is older than Latin Americans (36.3 years vs. 28.1 years; Pew Research Center, 2014). By 2055, it is projected that Asian Americans will surpass Latin Americans to become the largest immigrant group in the country (Pew Research Center, 2017).

Generally speaking, Asian Americans fare relatively well economically, educationally, and socially. For example, their median household income is \$73,060, 36% higher than the national average; their poverty rate is 3% lower than average at 12.1%; and just over half of Asian Americans hold a bachelor's degree or higher (20% above the national average). However, these outcomes vary radically by national origin, with certain groups (e.g., Asian Indians, Filipinos, Japanese) experiencing substantially better outcomes than others (e.g., Bangladeshi, Nepalese, Burmese). This also relates to the means by which Asian Americans become citizens; as a population that is more immigrant than native born, well-being is largely determined by the circumstances under which these individuals came to the United States. Thus, Asians arriving as refugees are much more challenged than those arriving as educated individuals seeking high-level opportunities and often lack access to sufficient medical and mental health care as a result. This may explain in

some part why mental health service use is lower in Asian American populations than in the U.S. population at large (Abe-Kim et al., 2007).

Latin Americans

Latino is an umbrella term that includes individuals with heritage from any Spanish-speaking country in North, Central, or South America, excluding European countries. The Latino population is the largest minority group in the United States, numbering more than 53 million, or 17.1% of the U.S. population, in 2013 (Pew Research Center, 2013). The Latino American population comes from every country in Latin America, with Mexican Americans making up the largest group (64.1% of all U.S. Latinos) and Puerto Ricans (9.5% of all U.S. Latinos) the second largest, followed by Cuban and Salvadorans, each making up less than 4% of the Latino population (as contributed by Ngo & Miranda, Chapter 2, this volume). As noted by Bernal, Adames, Mariani, and Morales (Chapter 6, this volume), the Latino population is expected to reach 128.8 million by 2060, when it will constitute 31% of the total U.S. population. Therefore, the Latino community is currently one of the fastest growing ethnic or racial groups in the United States. Of the 54 million Latinos in the United States as of 2013, 32.36% are under the ages of 18, 26.42% are between the ages of 18 and 33, 22.29% are between 34 and 39, 14.45% are between 50 and 68, and 4.47% are 69 years old and older (Pew Research Center, 2014). Indeed, this diverse population is expected to grow exponentially, from a minority to probably a numerical majority in the United States.

Although many Latinos share a heritage in terms of language, culture, and religion, there is also a great deal of diversity in terms of race (White, African, American Indian, and Asian), and national origin. In addition, history of migration to the United States and the experience of conquest and submission are important to consider, as in the examples of Mexico and Puerto Rico (Bernal & Enchautegui-de-Jesús, 1994). In another example, many Central Americans fled their homelands because of guerrilla warfare, counterinsurgency activities, and other war-related conditions (Lichter & Johnson, 2009). As such, themes of loss and trauma, as well as the stress of acculturation and poverty, are particularly important considerations for Central Americans. Undocumented immigrants have particularly difficult social and economic conditions.

Ngo and Miranda (Chapter 2, this volume) add that because 40% of the Latino American community is foreign born, Latino health is often shaped by factors such as low-income status, language and cultural barriers, lack of access to preventive care, lack of health insurance, and citizenship. For example, Latinos continue to have the highest uninsured rates of any racial or ethnic group within the United States and account for nearly a third of the total

nonelderly uninsured population. Although the Affordable Care Act (ACA) has been improving health care coverage by 11.8% for Latinos, noncitizens, including lawfully present and undocumented immigrants, who make up nearly half the uninsured Latino population, will continue to face eligibility restrictions for health coverage under the ACA (Uberoi, Finegold, & Gee, 2016). These sociopolitical factors are critical access barriers to health care for the Latino community and therefore are important considerations when providing mental health services.

Despite the heterogeneity in their migration history and sociocultural context, Latinos as a whole share certain sociodemographic characteristics related to their minority status; language access; exposure to poverty and adversities associated with poverty, such as inadequate housing; and a high rate of single-parent households. As immigrants, they also face discrimination and racism in addition to the acculturative stress of adjusting to the U.S. majority culture. These contextual factors shape the living context and mental health needs of this diverse community and may affect the expression of depression and its assessment and treatment.

African Americans

The Black or African American population of the United States includes individuals whose ancestry traces to the continent of Africa or the Afro Caribbean islands who self-identify as part of this racial and ethnic group. Although the total U.S. population grew by 9.7% between 2000 and 2010, the Black population grew by 15% to a total of 42 million people (13.6% of the U.S. population; Rastogi, Johnson, Hoeffel, & Drewery, 2011). Within the United States, the majority of Black people are descended from enslaved West African people brought to this continent during the colonial period; however, Black immigration to the United States has increased significantly in the last 30 years, such that now a record 3.8 million Blacks in the United States are foreign-born (Pew Research Center, 2015). African Americans are a relatively young population, with over 40% being under the age of 26 and only 10% over the age of 65 (compared with 30% and 17% of Whites, respectively; Duckett & Artiga, 2013). African Americans are largely concentrated in the South, with 55% of these individuals living in this geographic region. Thus, they make up a full 20% of the Southern population but only between 6% and 13% of the population in other regions, and they are further concentrated in every region in large metropolitan areas. African Americans are more likely than any other racial or ethnic group to live within the limits of large cities (rather than in suburbs, exurbs, or rural areas; Rastogi, Johnson, Hoeffel, & Drewery, 2011), making this group the most likely to experience the challenges of high population density, urban decay, and neighborhood gentrification.

Disparities in education, income, wealth, and personal health between Whites and Blacks in the United States have existed since the country's founding. However, since the Great Recession of 2008, Blacks have seen the erosion of indices of well-being relative to Whites, with their wealth gap having been set back to levels not seen in the United States since the early 1990s. Holding wealth that is 1/13th that of Whites, Blacks experience the greatest measured wealth disparity by race in U.S. society (Kochhar & Fry, 2014). About one in four African Americans lives in poverty, a rate much higher than the national rate of 14.3%. High rates of poverty among Blacks can be found in all regions of the United States, with several states across the Upper Plains and Midwest and in the South evidencing poverty rates of 30% or more among Blacks (Macartney, Bishaw, & Fontenot, 2013).

African Americans are overrepresented in the uninsured population generally, and uninsured rates for Blacks are actually highest in states with the highest proportion of Blacks as residents (i.e., in the South). For example, only 9% of Blacks in Delaware are uninsured, whereas 30% of Blacks in Louisiana are (Duckett & Artiga, 2013). Accordingly, very good or excellent self-reported health among Blacks lags behind that of Whites by about 5%, and significantly higher obesity, hypertension, and mortality rates are also in evidence for Blacks (Kochanek, Murphy, Xu, & Tejada-Vera, 2016). With so many challenges, it is not surprising that mental health needs among African Americans are great; rates of depression and anxiety are high in this population (estimated at 36.9% and 66.6% of Black psychiatric patients, respectively). However, access to mental health care is an ongoing issue, particularly care aligned with minimum recommendations for effectiveness (Hines, Cooper, & Shi, 2017).

Native Americans

Boyd and Hunsaker (Chapter 12, this volume) describe the demographics of American Indian and Alaska Native (AI/AN) people as a proportionally small but extremely diverse group. Approximately 5.4 million people, or 1.7% of the total U.S. population, self-identify as AI/AN (Norris, Vines, & Hoeffel, 2012). Approximately 60% of American Indian people in the United States currently live in metropolitan areas, with 22% on tribal reservations or territories and the greatest concentrations residing in the West, Southwest, and Midwest (Norris, Vines, & Hoeffel, 2012; U.S. Department of the Interior, Indian Affairs, 2015). Young people under the age of 18 make up about 30% of the AI/AN population (U.S. Department of Health & Human Services Office of Minority Health, 2012). AI/ANs are a heterogeneous group: There are currently 566 federally recognized AI/AN groups in the United States, with more than 100 additional state-recognized tribes. Each tribal group is unique, with its own distinct culture, language, traditions,

histories, and identities. Almost 200 different Native languages are still spoken in the United States (U.S. Department of the Interior, Indian Affairs, 2015), but the number of fluent speakers and the level of acculturation to Western culture varies widely across tribal groups.

McDonald, Ross, Kilwein, and Sargent (Chapter 4, this volume) note that before European contact, the indigenous population was as high as 18 million and consisted of at least 600 different tribes (Graham, 2002). Decades of war and disease decimated the Native American population by the late 1800s (McDonald & Chaney, 2003). The Native population has since significantly increased from an estimated low of 248,253 in 1890 to around 2.9 million, or 0.9% of the total American population (U.S. Census Bureau, 2011).

One third of American Indians live in poverty. The annual median income for Native Americans is estimated at \$35,192, in comparison with \$50,502 for the nation as a whole (U.S. Census Bureau, 2012). As McCullagh and Gray note in Chapter 8 of this volume, AI/ANs are more likely to struggle with homelessness and unemployment, live in substandard housing, and have lower levels of educational attainment (Freeman & Fox, 2005) than other ethnic groups. AI/ANs also tend to be uninsured at higher rates compared with the general population, which results in reduced physical and mental health care use (Gone & Trimble, 2012; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004). For example, in 2015, over one in five American Indian people were without health care coverage (Centers for Disease Control and Prevention, 2015). Many of the communities in which AI/ANs live are characterized by poor infrastructure and extremely limited access to mental health services. The multiple social problems, minimal access to mental health resources, poverty, and legacy of historical trauma are all believed to contribute to contemporary mental health disparities among AI/ANs. AI/ANs are more likely to suffer from alcohol abuse and dependence and posttraumatic stress disorder (PTSD), and to have a greater prevalence of conduct disorders among children and adolescents, higher suicide rates among adolescents, and greater likelihood of experiencing physical and sexual violence, compared with the general population (Beals et al., 2005; Gone & Trimble, 2012; Gray & McCullagh, 2014; Indian Health Service, 2011; Wahab & Olson, 2004).

OVERVIEW OF THIS VOLUME

To meet the needs of the predicted change in the diversity of our society and to prevent the disparity in mental health services for members of ethno-racial groups from growing larger, it is essential to improve evidence-supported

models, measures, and treatments by understanding how they work for specific ethnoracial groups. It was from this realization that we developed this volume. The book is divided into three main sections, each focusing on a robust concern for mental health treatment—namely, working with individuals experiencing clinically significant symptoms of depression, anxiety, or stress. We focused on these conditions because they represent some of the most common conditions for which individuals seek mental health treatment. Within each section, separate chapters are devoted to the discussion of depression, anxiety, or stress specific to Asian Americans, Latin Americans, African Americans, and American Indians.

Part I focuses on CBMMTs of depressive disorders. In Chapter 1, Hwang, Ho, Chan, and Hong examine CBMMTs for depressive disorders among Asian Americans. Focusing on findings from large epidemiological surveys, the important challenges to consider in conceptualizing and assessing for depression in Asian Americans are discussed. Furthermore, Hwang et al. review methods of assessing depression in Asian American populations and note the dearth of research examining treatment efficacy with Asian Americans. The chapter concludes with notes on the importance of culturally adapting CBT and provides suggestions for future clinical and research directions on how to best culturally adapt CBMMTs.

In Chapter 2, Ngo and Miranda discuss CBMMTs for treating depressive disorders among Latin Americans. They discuss depression prevalence and risk factors, as well as cultural-specific expressions of mental health distress. Also central to the chapter is the discussion of validated measures of depression for use with Latino Americans and noted cautions for interpretations of assessment results. Ngo and Miranda end the chapter with a review of extant cognitive behavioral models and interventions for Latino Americans and note that although CBMMTs should take into account the diverse individual differences of Latino American culture, interventions and measurements that have been common to European American, White populations appear to be largely effective for Latinos.

In Chapter 3, Neblett, Sosoo, Willis, Bernard, and Bae discuss CBMMTs for depressive disorders in African Americans. The authors begin with an overview of depressive disorders among this population and note the factors (e.g., exposure to racism) that may contribute to greater risk for experiences of depression and depressive disorders among African Americans despite lower prevalence rates of depression according to epidemiological studies. Neblett et al. comment on the shortage of cognitive behavioral models specific to understanding depressive disorders in African Americans and that take into account the sociocultural characteristics, social, and/or cultural values and perspectives of African Americans. The authors provide distinctions between, and examples of, traditional, culturally adapted, and

culturally tailored cognitive behavioral models of depressive disorders for African Americans. Furthermore, they review common assessment measures and treatments of depressive disorders for use with African Americans.

Finally, in Chapter 4, McDonald, Ross, Kilwein, and Sargent examine CBMMTs for depressive disorders in American Indians. Having an understanding of how wellness, body, mind, and spirit are conceptualized within the American Indian population is imperative for providing and/or creating culturally congruent measures and treatments of depression for use with American Indians. To illustrate the important considerations when conceptualizing, measuring, and treating depression in American Indians, McDonald and his colleagues provide a vignette in the chapter to show cultural adaptations to traditional cognitive behavioral approaches for depression and argue for the importance of future research and assessment to ensure the effectiveness of culturally adapted CBMMTs of depression.

Part II focuses on the review of CBMMTs of anxiety disorders. In Chapter 5, Hong examines CBMMTs for anxiety disorders in Asian Americans, with a primary focus on the sociocultural influences and maintenance factors related to social anxiety. Hong describes cognitive behavioral models for understanding anxiety disorders in Asian Americans and notes how existing models of anxiety disorders may not take into account sociocultural influences. The author reviews cognitive behavioral measures of anxiety disorders in Asian Americans and describes cognitive behavioral treatments of anxiety disorders for Asian Americans. Given the dearth of data, Hong argues that there is no clear understanding of which cultural adaptations would be most useful for anxiety disorders in Asian Americans; the chapter ends with a discussion of possible future directions for CBMMTs for anxiety disorders in Asian Americans.

In Chapter 6, Bernal, Adames, Mariani, and Morales review CBMMTs for anxiety disorders in Latino Americans. In this chapter, Bernal and colleagues examine through a systematic review of the literature whether available treatments for anxiety that are delivered to Latinos in the United States are effective. They review the CBT models and treatment manuals used in the identified studies from their systematic review and also review cognitive behavioral assessment instruments for use with Latinos. Bernal et al. note that although cognitive behavioral treatments for anxiety appear to be effective for the treatment of anxiety conditions in Latinos, effectiveness may depend on a number of factors (e.g., acculturation more research is needed to test the effectiveness of CBT in this population).

In Chapter 7, Carter and Sbrocco examine CBMMTs for anxiety disorders in African Americans. The authors discuss traditional cognitive behavioral models of anxiety disorders as well as cognitive behavioral models of anxiety that have included cultural influences on anxiety for African Americans.

The authors describe useful and validated measures of general anxiety experiences as well as specific anxiety disorders for African Americans, and they also note some inconsistencies in the efficacy of other measures of anxiety. Furthermore, Carter and Sbrocco discuss findings from treatment outcome studies to examine whether extant cognitive behavioral treatments are effective for treating anxiety among African Americans.

In Chapter 8, McCullagh and Gray review CBMMTs for anxiety disorders in American Indian and Alaska Natives. The authors begin with a discussion of the context of mental health concerns among American Indian and Alaskan Natives. They discuss culturally congruent models of treatment and healing through which cognitive behavioral models could be adapted. McCullagh and Gray report on appropriate assessment measures of anxiety for use with American Indians and Alaska Natives, as well as their limitations. The authors note some important considerations for how clinicians can establish stronger therapeutic relationships with American Indian and Alaska Native clients, as well as how to integrate important cultural factors and values into treatment.

The focus of Part III is on CBMMTs for stress. In the first chapter of this part, Chapter 9, Chu, Batchelder, and Poon review CBMMTs for stress in Asian Americans. The authors begin with a brief overview of stress itself, stress as it relates to Asian Americans, and barriers to mental health treatment use by Asian Americans. Main stress theories and models are presented, followed by a review of various cultural factors and how they may influence or be valuable to incorporate into existing stress theories. Taking into account the number of cultural variables that contribute to stress and affect the expression of stress and the coping methods used by Asian Americans, the authors comment on the applicability of cognitive behavioral treatments for stress in these groups. Chu et al. provide some useful cultural considerations and adaptations to cognitive behavioral approaches to reduce barriers to seeking or engaging in treatment.

In Chapter 10, Cardemil, Edwards, Nelson, and Loyo write about CBMMTs for stress in Latino Americans. This chapter begins with an overview of stress in Latinos and describes current as well as historical contexts that may contribute to stress in this population. Cardemil and colleagues address the models and theories used to understand PTSD and acculturative stress in Latinos. They review useful assessment measures of PTSD and acculturative stress. The chapter concludes with some future directions for CBMMT for stress in Latinos—namely, the need for more research to fill gaps in the literature and the development and evaluation of assessment measures and interventions for stress in Latinos.

In Chapter 11, Greer, Brondolo, Amuzu, and Kaur review CBMMTs for stress in African Americans. The authors begin with an overview of the

racial disparities in stress exposure that then contribute to disparities in other life areas. To conceptualize stress, the authors discuss the relationship between racism exposure and stress and describe useful measurements of race-related stress. Cognitive conceptualizations of stress that take into account how individuals within the African American community appraise threat and harm are reviewed. Greer et al. address benefits and limitations to cultural adaptations of cognitive behavioral treatments and discuss alternative treatment approaches to CBTs (e.g., meditation, yoga) for stress reduction in African Americans.

In the last chapter of Part III, Chapter 12, Boyd and Hunsaker discuss CBMMTs for stress in American Indians and Alaska Natives. The authors first briefly describe the AI/AN population, the stressors they face, important health disparities, and the historical trauma that contributes to the contextual understanding of stress in this population. After describing general stress and models of stress, Boyd and Hunsaker provide more detailed information on specific stressors for AI/ANs (e.g., psychological strains of historical trauma, environmental stressors). In addition, the importance of addressing stress in relation to other health concerns prevalent in the AI/AN population (e.g., diabetes, cardiovascular disease) is noted.

In Chapter 13, we conclude the book with an overview of common themes and concepts addressed in previous chapters. Specifically, in the interaction of culture with context, factors that are important to consider in relation to CBMMTs for racial and ethnic groups may be factors such as acculturation, language, cultural history, historical trauma, and stigma of mental illness. We argue for the importance of understanding the context and specific circumstances involved with the expression and experience of depression disorders, anxiety disorders, and stress disorders in the groups of focus for the book. In addition, we discuss the interaction of race and ethnicity with social class that may influence access to treatment and, particularly, culturally sensitive treatments that, in turn, may add to the mental health disparities that were mentioned in the previous chapters. Finally, we raise considerations and challenges for the notion that underlying cognitive behavioral concepts may not always adequately correspond to concepts of depression, anxiety, and stress in diverse groups.

CONCLUDING THOUGHTS

Although this volume focuses on cognitive behavioral approaches, we are mindful that there are many other approaches to conceptualizing, measuring, and treating psychological problems (Rotheram-Borus, Swendeman, & Becker, 2014). We are also mindful of the dangers associated with ascribing

privilege to any singular theory or paradigm for understanding human behavior (Scarr, 1985) because this may hinder the development of innovative theories and paradigms in the near future (Govrin, 2014). That said, it was more than 20 years ago in one of the earliest publications to highlight the need to consider ethnoracial factors in applying CBT that Hays (1995) provided the following forethought:

As the number of psychologists of minority cultures and groups increases, it is likely that cognitive-behavior therapy will become increasingly attentive to cultural influences and minority groups. The attention will no doubt lead to the recognition of an even more diverse range of helping strategies. Moreover, it should contribute to the improved effectiveness of cognitive-behavior therapy with specific groups of people whose mental health needs have been neglected. (p. 313)

In this context, we hope that this volume can play an instrumental role in helping all mental health professionals, regardless of their ethnoracial status and background, to find value and guidance when working with diverse adults, and we hope that researchers and practitioners will come to value the rich spectrum of CBMMTs provided here. This would include finding ways to apply some of these situated conceptualizations and techniques to ultimately help facilitate greater growth and meaning for all individuals seeking to improve the conditions and contexts of their lives. Finally, we hope that readers of this volume will also appreciate the wealth of opportunities to cross-fertilize the diverse ideas, methods, and techniques presented herein as we move toward a society that is becoming increasingly rich in diversity and complexity.

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