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Interventions for African American Male Youth With Internalizing Symptoms of Depression, Anxiety and Traumatic Stress: A Comprehensive Review

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ABSTRACT

African American male youth have experienced substantial increases in suicidality and self-harm over the past 15 years, signalling rising rates of internalizing symptoms such as anxiety, depression and traumatic stress. Despite these trends, research involving African American boys and young men has focused disproportionately on externalizing behaviours, leaving clinicians, educators and mental health professionals with limited guidance regarding evidence-based interventions for internalizing concerns. This comprehensive review summarizes and evaluates the existing intervention literature targeting anxiety, depression, and traumatic stress among African American male youth and provides recommendations for diagnosis and treatment. A systematic search of nine databases, including Academic Search Ultimate, CINAHL, ERIC, MEDLINE, PsycARTICLES, Psychology and Behavioural Sciences Collection, PsycINFO, SocINDEX and Scopus, was conducted from database inception through 15 September 2025. Studies were included if they evaluated interventions targeting internalizing symptoms among African American male youth. Six studies met inclusion criteria from 8693 unique records. All included studies employed quantitative methodologies and used pre-post intervention designs to assess treatment outcomes. Findings suggest that cognitive behavioural therapy and adapted forms of cognitive behavioural interventions may reduce symptoms of anxiety, depression and traumatic stress among African American male youth. However, the small number of eligible studies highlights a significant gap in the intervention literature. Additional culturally responsive intervention research is urgently needed to strengthen the evidence base and improve diagnosis, treatment and mental health service delivery for African American male youth experiencing internalizing symptoms.

1 | Introduction

The history of psychological diagnosis and treatment for mental health disorders among African American youth is inextricably linked to the broader context of anti-Black racism in the United States (U.S.). It has long been the subject of critique, as this legacy has influenced issues of misdiagnosis and underdiagnosis among African Americans (Auguste et al. 2023; Cummings and Cummings 2021; K. Davis 2018; Shim 2021; Suite et al. 2007). Black scholars in the field of psychology have played a central role in exposing how diagnostic and treatment practices have perpetuated harmful and racist stereotypes about Black

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Summary

- African American male youth are frequently overrepresented in diagnoses of externalizing disorders (e.g., attention deficit disorder, oppositional defiant disorder and conduct disorder) while being underrepresented in diagnoses and treatment interventions for internalizing disorders (e.g., anxiety, depression and traumatic stress).
- Despite their increased risk of exposure to chronic systemic and interpersonal trauma, which heightens their vulnerability to developing anxiety, depression and traumatic stress symptoms, interventions to address these internal experiences are overlooked in favour of externalized behaviours.
- This study summarizes and critiques the scholarly literature on the treatment of African American male youth with anxiety, depression and traumatic stress symptoms. It offers recommendations for assessment, diagnosis and treatment to address research gaps and improve care for psychological distress in this population.

children (Cokley and Garba 2018). Indeed, the founding of the Association of Black Psychologists emerged as a direct challenge to the American Psychological Association, to confront and rectify dehumanizing and culturally inappropriate practices that harmed Black children and families (R. Williams 1974). Despite ongoing efforts to address these concerns, the legacy of racism remains embedded in contemporary diagnostic frameworks and clinical practices (American Psychiatric Association 2021; American Psychological Association 2021). Consequently, mental health clinicians and assessment tools continue to reproduce racial bias, contributing to cultural mistrust for mental health systems and disparities in access (Carlisle and Murray 2020; Scott et al. 2011), leaving many Black youth untreated or without adequate resources to address internalizing symptoms such as depression, anxiety and traumatic stress (Faber et al. 2023; Opara et al. 2021). This ongoing lack of access to appropriate care is particularly concerning as the demand for clinical mental health intervention among Black children and adolescents continues to rise.

In the United States, African American youth face increasingly high rates of negative mental health outcomes (Xu et al. 2025). Recent data indicate rising rates of suicide, depression, and anxiety among Black children and adolescents (Kaur et al. 2024). Between 2018 and 2021, suicide rates among Black youth increased by 36% (Stone et al. 2023), and hospital-based data show a corresponding rise in emergency department visits for mental health concerns among Black children and adolescents over the past decade (Kalb et al. 2019; Lo et al. 2020). Taken together, these trends underscore the urgent need to address mental health across the life course for Black youth. Within this broader pattern, there is a critical need to centre the mental health of Black male youth, whose rates of mental health concerns have been rising for more than a decade. Between 2001 and 2017, suicide rates among African American male youth increased by 60% (J. H. Price and Khubchandani 2019), and more recent evidence documents increases in anxiety, depression and suicide-related diagnoses among Black male youth aged 8–20 between 2015 and 2022 (Prichett et al. 2024).

More broadly, the mental health of youth is shaped by a constellation of biological, social and structural determinants (Alegría et al. 2018). Developmental stressors during childhood and adolescence increase vulnerability to mental health difficulties for all youth; however, Black male youth encounter these age-related stressors alongside distinct gendered and racialized stressors that further exacerbate risk (Reck et al. 2024). Longstanding systemic disinvestment and structural oppression in Black communities have created conditions that disproportionately expose Black male youth to traumatic stressors (Burrell et al. 2021; Harris et al. 2021). Across the lifespan, Black male youth experience significantly higher rates of witnessing and direct exposure to community violence, which has been consistently linked to adverse mental health outcomes (Jones-Eversley et al. 2020; Meza et al. 2023; Ruchkin et al. 2023; Smith and Patton 2016). Additionally, disproportionate exposure to justice system involvement, incarceration and police violence has serious implications for the development of internalizing symptoms among Black male youth (Gearhart et al. 2022; Smith Lee and Robinson 2019; Turney 2021). Importantly, not all Black male youth experience adversity through violence or justice system contact. Many are exposed to other chronic stressors such as poverty, racial profiling, discrimination and other forms of structurally driven trauma as well as interpersonal traumas such as emotional, physical, sexual abuse and neglect (Assari et al. 2017; Cotton and Shim 2022; Salami et al. 2022; Salimi-Jazi et al. 2024; Sheats et al. 2018). These adverse childhood experiences have implications for the onset of depression, anxiety and traumatic stress symptoms that persist into adulthood, and have been linked to premature mortality (Jones-Eversley et al. 2020). Taken together, this body of evidence underscores the urgency of advancing clinical and empirical research to address the psychological distress of this population.

1.1 | Presentation of Internalizing Disorders

The expression of depression, anxiety and traumatic stress symptoms are often expressed similarly among children and adolescents, particularly those who have been chronically exposed to traumatic events. *Depressive disorders* are cyclical mood disorders characterized by persistent sadness, diminished interest or pleasure in previously enjoyable activities, sleep disturbance, low energy and feelings of hopelessness, with symptoms present for at least 2 weeks. Diagnostic specifiers further describe the system severity of symptoms, course and the presence of co-occurring features, including anxiety-related symptoms.

Generalized anxiety disorder and post-traumatic stress disorder (PTSD) were previously classified within the broader cluster of anxiety disorders; however, they were separated into distinct anxiety and trauma-related disorder categories in the fifth edition of the *Diagnostic Statistical Manual of Disorders* (American Psychiatric Association, 2013). Although ‘anxiety’ is often used colloquially to refer to generalized anxiety disorder, this diagnostic category is defined by excessive and uncontrollable worry about everyday concerns, accompanied by symptoms such as irritability, sleep disturbance, difficulty concentrating,

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physiological arousal (e.g., rapid heart rate or sweating) and persistent feelings of apprehension or panic, occurring for at least 6 months (American Psychiatric Association 2022).

PTSD is distinct in its emphasis on aetiology, as symptoms emerge following exposure to a traumatic event in which the individual, or someone close to them, experienced or feared serious harm. PTSD symptomatology may include hypervigilance, intrusive memories or flashbacks, avoidance of trauma-related stimuli, negative mood and cognitions, dissociation, sleep disturbance and impaired concentration (American Psychiatric Association 2022). These symptoms typically emerge within 1 month of traumatic exposure and persist for longer than 6 months.

Symptoms that disrupt daily functioning are key clinical indicators of depression, anxiety and PTSD. Importantly, functional impairment can occur even when an individual does not meet the full diagnostic criteria for a disorder. This distinction is particularly salient for PTSD, which helps explain why much of the literature focuses on *traumatic stress symptoms* rather than the disorder itself. Similarly, depressive and anxiety symptoms may significantly interfere with daily functioning despite falling below diagnostic thresholds. These conditions and their associated presentations are referred to as *internalizing symptoms* because they are primarily experienced internally and are not inherently directed outward toward others, though they may include suicidal ideation or self-injurious behaviours (Buitron et al. 2018).

At the same time, internal distress can be expressed behaviourally, particularly among children and adolescents. Symptoms such as irritability, sleep disturbance, concentration difficulties and negative mood are often externalized through behaviours including defiance, classroom disruption, aggression and other risk-related behaviours (Marshall et al. 2015). This pattern, sometimes described as the *externalization of internalizing symptoms*, is especially common among cisgender boys, for whom gender socialization and societal expectations often discourage emotional expression and instead reward emotional control and assertiveness. As a result, cisgender boys are disproportionately diagnosed with externalizing disorders such as attention deficit hyperactivity disorder, oppositional defiant disorder and conduct disorder. These diagnostic disparities are further amplified for African American boys, whose emotional and behavioural expressions are interpreted through the dual lenses of masculine gender norms and racialized stereotypes that frame them as inherently aggressive, dangerous or disruptive (Stevenson 2016; Watkins et al. 2016).

Aetiology is not explicitly incorporated into the diagnostic criteria for depression and anxiety, whereas PTSD requires exposure to a distressing event, with symptoms understood in relation to that experience. Notably, none of these diagnostic frameworks formally account for the unique and cumulative impact of racism on mental health. *Racial trauma* emerges from persistent and pervasive experiences of racism and discrimination across the life course, with particularly pronounced effects in the lives of Black male youth and men (Assari et al. 2017; Sami 2024). These experiences begin in childhood and adolescence and are associated with increased risk for depression, anxiety and PTSD symptomology, as well as decreased life satisfaction, elevated substance use and somatic complaints (M. T. Williams et al. 2018).

Within this context, symptoms commonly associated with PTSD, such as hypervigilance, heightened reactivity and dissociation, may function as adaptive responses to chronic racial threat and discrimination. Hypervigilance can support safety, enabling individuals to continue functioning amid repeated assaults. Empirical work supports these connections. In a study of 230 Black adults, Roberson and Carter (2022) found that race-based traumatic stress symptoms were associated with higher traumatic stress system scores, with depression, low self-esteem, intrusion and anger emerging as key predictors of overall trauma severity. Although racial trauma is not the primary focus of this comprehensive review, acknowledging its relevance is essential for understanding why culturally relevant approaches are necessary when conceptualizing interventions and treatment for African American boys (Turner 2019).

Scholars in the fields of education, developmental psychology and social work have consistently demonstrated that Black male youth's psychological and socioemotional functioning is shaped by the intersection of racialized structural conditions, gendered socialization processes and institutional environments. Disciplinary practices, deficit narratives and inequitable school climates contribute to chronic stress, disengagement and diminished socioemotional well-being of African American boys. Black male youth's mental health is situated within broader ecological and developmental systems, highlighting how cumulative exposure to adversity and structural inequality shapes trajectories of risk and resilience (J. E. Davis 2006, 2009; Howard 2013; Marsh and Noguera 2018; Noguera 2003). This body of work underscores that symptoms of depression, anxiety and traumatic stress among Black male youth are not simply individual-level phenomena but are embedded within multilevel contexts characterized by structural racism, environmental stressors and culturally specific coping processes. Despite well-documented structural and psychosocial challenges facing Black male youth, internalizing symptoms have frequently been overlooked in favour of disproportionately emphasizing externalizing behaviours, such as aggression, delinquency and other antisocial conduct, thereby perpetuating longstanding stereotypes that pathologize Black male youth as criminal, deviant or inherently disordered (Bell et al. 2015; Breland-Noble et al. 2016; Levesque 2011; Watkins et al. 2016). Black male youth continue to endure a critical gap in the clinical intervention literature, which has historically underexamined how these contextual and developmental realities should inform the design, adaptation and implementation of mental health interventions. Clinical intervention studies of depression and anxiety have historically centred white populations, and when Black male youth are included, they are often aggregated with Black girls, limiting analytic specificity.

This methodological pattern produces several consequences: Black male youth are frequently underpowered for subgroup analyses, gendered-racial nuances are obscured and findings are generalized to Black male youth without sufficient empirical justification. Despite these limitations, intervention development has continued to evolve, incorporating trauma-informed

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practices, cognitive–behavioural-based techniques, community-based approaches and cultural adaptations (Arora et al. 2021; Ginsburg and Drake 2002; Lindsey et al. 2018; M. A. Price et al. 2022). Consolidating and critically examining this emerging body of work is therefore necessary to identify areas of promise, gaps in evidence and directions for future intervention development aimed at addressing depression, anxiety and traumatic stress symptoms among Black male youth.

In this comprehensive review, *African American* is used to describe participants in the included studies, reflecting the terminology used by study authors. The term *Black* is used more broadly when referencing prior scholarship, consistent with the language employed in those sources. We recognize that these terms are not synonymous and may reflect distinct cultural and historical identities.

1.2 | Aims, Objectives and Research Questions

The aims of this comprehensive review are (1) to summarize and critically examine existing intervention designs, efficacy, effectiveness and reported outcomes for African American male youth experiencing symptoms of anxiety, depression and/or traumatic stress; and (2) to synthesize patterns across these studies to inform future clinical and scholarly approaches to treatment for this population.

The objectives of the review are to identify the characteristics, therapeutic approaches and reported outcomes of mental health interventions implemented with African American male youth in clinical, school-based and community-based settings for symptoms of depression, anxiety and/or traumatic stress.

The following research question guided this comprehensive review: Among African American male youth aged 5–23 in the United States what clinical intervention approaches have been evaluated for reducing symptoms of depression, anxiety and/or traumatic stress?

2 | Methods

2.1 | Protocol and Registration

This comprehensive review was conducted in accordance with *the JBI Manual for Evidence Synthesis* (Peters et al. 2024) and the *PRISMA-ScR (Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews)* guidelines (Tricco et al. 2018). A protocol specifying the objectives, eligibility criteria and methodological approach was developed a priori and registered with the *Open Science Framework* registry (Barrie et al. 2023).

2.2 | Search Strategy and Information Sources

The search strategy was informed by the PICO framework (Richardson et al. 1995) and developed using relevant articles previously identified by the lead author. The framework included the following: population (African American male youth aged 5–23 years living in the United States); interventions (clinical, school-based, community-based, church-based and similar interventions); comparison (no comparison group required); and outcomes (depression, anxiety or traumatic stress). Preliminary searches were conducted in Google Scholar and EBSCO databases to refine keywords and identify controlled vocabulary terms (e.g., subject headings, MeSH terms). Search term synonyms and related terms were identified for each PICO element (see Supporting Information S1). Consistent with comprehensive review methodology, broader behavioural and psychosocial terms (e.g., aggression, substance use, misbehaviour) were incorporated to maximize sensitivity and capture studies in which internalizing symptoms may have been embedded within externally framed presentations.

Nine electronic bibliographic databases were searched from inception through 15 September 2025, using the EBSCO platform (including Academic Search Ultimate, CINAHL, ERIC, MEDLINE, PsycARTICLES, Psychology and Behavioural Sciences Collection, PsycINFO, SocINDEX), and the Elsevier interface (Scopus). Full search strategies for each database are provided in Supporting Information S2. Grey literature was not included. Reference lists of included studies were reviewed to identify additional eligible articles.

2.3 | Eligibility Criteria and Study Selection

Predefined inclusion and exclusion criteria were applied to identify peer-reviewed studies published in English-language academic journals between 2000 and 2025. Eligible studies focused on Black cisgender male youth aged 5–23 years residing in the United States and experiencing symptoms of depression, anxiety and/or traumatic stress. Studies were required to examine mental health clinical interventions, regardless of setting, including clinical, school-based, community-based or church-based. Both qualitative and quantitative empirical studies were included regardless of design; review articles were excluded, although their reference lists were screened for additional relevant studies.

Study selection occurred in three stages. First, preliminary searches were used to identify benchmark articles and finalize search terms. Second, all retrieved citations were imported into Zotero, a citation management tool for de-duplication (Puckett 2017) and then uploaded to Rayyan for title and abstract screening (Ouzzani et al. 2016). Two reviewers independently screened all records against the eligibility criteria. Third, full-text screening was conducted for articles that met the initial criteria, with disagreements resolved by a third reviewer.

2.4 | Data Charting and Analysis

Data were extracted using a predefined Excel charting form by one reviewer and verified by a second reviewer. Extracted data included study setting, population characteristics, participant demographics, intervention components, study design, recruitment and retention information, outcome measures and reported intervention effects. Consistent with PRISMA-ScR guidance, formal assessment of methodological quality or risk of bias was not conducted, as the purpose of this comprehensive

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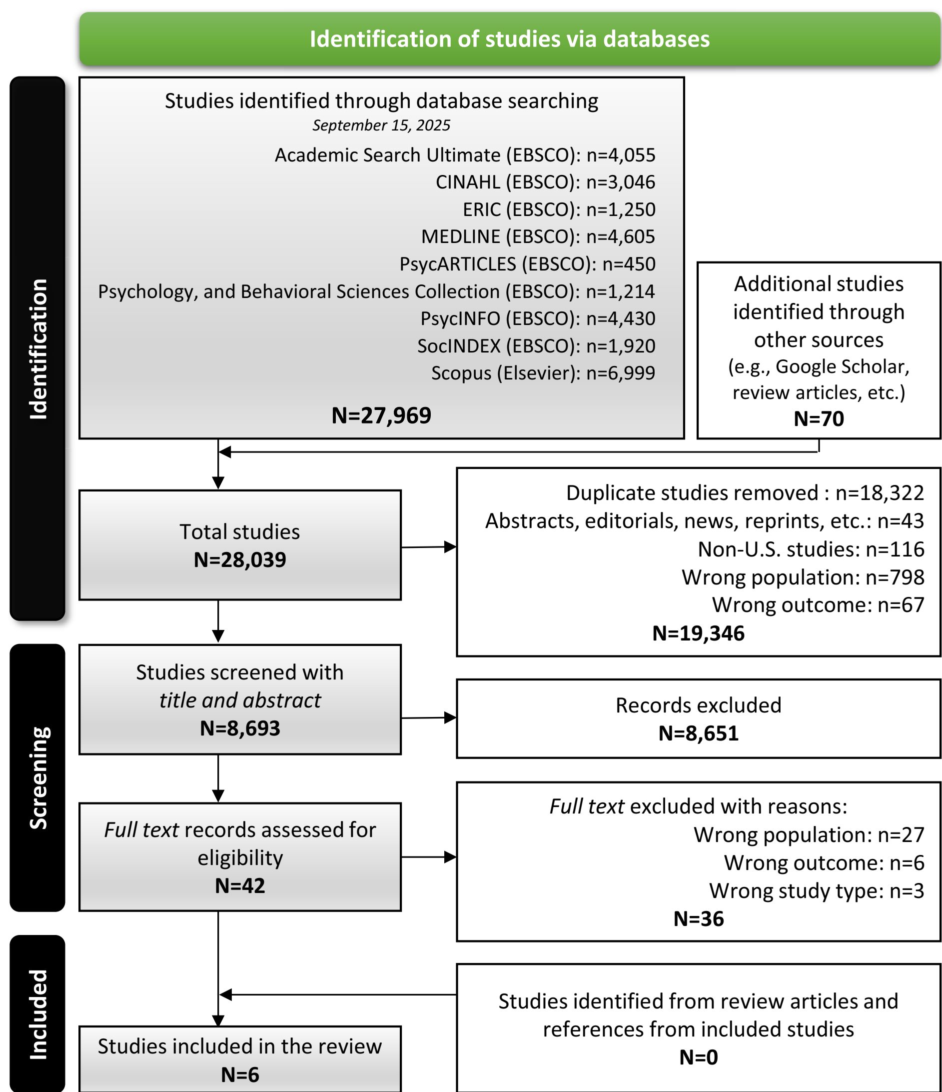

FIGURE 1 | PRISMA flow chart of the study selection process.

review was to map the scope and characteristics of available evidence rather than evaluate intervention effectiveness (Munn et al. 2018; Tricco et al. 2018).

Results were synthesized using a narrative and thematic approach. Data were organized and coded in Dedoose to systematically chart intervention characteristics and outcomes (Salmona et al. 2020). Coding focused on population features, intervention structure and delivery, targeted symptoms, measurement tools and reported changes in symptoms. Themes and patterns were identified deductively based on the review objectives and data extraction domains, consistent with comprehensive review methodology.

3 | Results

3.1 | Selection of Studies

The selection process is presented in the PRISMA 2020 flow diagram (Figure 1). The search yielded 8693 unique records after duplicate removal. Following title and abstract screening, 8651 records were excluded. An additional 36 articles were excluded during full-text review due to incorrect population, outcome or study type. Six studies met the inclusion criteria and were retained for analysis (Cooley-Strickland et al. 2011; Salloum and Overstreet 2012; Stewart et al. 2021; Tandon et al. 2015; Thomas et al. 2021; Waldrop and de Arellano 2004).

Minor refinements to the protocol were made during screening to better align with the review's objectives. First, studies with mixed-gender samples were retained when African American males comprised at least 50% of participants. This clarification ensured that findings remained meaningfully representative of the target population while avoiding unnecessary exclusion of relevant intervention research. Second, the lower age limit was extended from 8 to 5 years to capture early school-aged boys, consistent with the developmental focus of the review. The final age range of 5–23 years reflects the developmental continuum from early childhood through emerging adulthood and aligns with youth-serving mental health systems that frequently extend into transitional age.

Additionally, the search was limited to studies published between 2000 and 2025 to capture contemporary intervention approaches

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that reflect current diagnostic criteria, treatment modalities and sociocultural contexts influencing African American boys' mental health. Given substantial changes in diagnostic frameworks (e.g., from the DSM-IV-TR to DSM-5), service delivery systems and culturally responsive intervention models over the past two decades, restricting the timeframe enhanced the relevance and applicability of findings to current clinical and research practice (American Psychiatric Association 2000, 2022). All studies screened prior to these refinements were re-reviewed to ensure consistency with the updated criteria. Reference lists of included studies were also screened; however, no additional studies met the inclusion criteria.

3.2 | Characteristics of Included Studies

Table 1 summarizes key characteristics of the six included studies, including population demographics, intervention type, targeted outcomes and main findings.

3.2.1 | Population Demographics

Sample sizes across the six studies varied substantially, ranging from single-participant case studies (Stewart et al. 2021; Waldrop and de Arellano 2004) to a large school-based intervention involving 514 participants (Thomas et al. 2021) and a moderate-sized group, a school-based intervention involving 70 participants (Salloum and Overstreet 2012). Five studies described participants as '*youth-at-risk*', based on contextual indicators such as: high proportions of students receiving free or reduced-price lunch (Cooley-Strickland et al. 2011; Stewart et al. 2021), exposure to violence (Salloum and Overstreet 2012), unstable housing, or general education development (GED) attainment (Tandon et al. 2015). Waldrop and de Arellano (2004) provided limited demographic detail beyond race, age, gender and presenting concern.

Only two studies included single-gender samples, each consisting of one African American male participant (Stewart et al. 2021; Waldrop and de Arellano 2004). The remaining four studies employed mixed-gender samples in which African American boys constituted at least half of the participants (Cooley-Strickland et al. 2011; Salloum and Overstreet 2012; Stewart et al. 2021; Thomas et al. 2021). Across all six studies, participants were predominantly African American, with each sample comprising at least 95% African American youth.

3.2.2 | Therapeutic Interventions

All six studies implemented evidence-based intervention approaches tailored to their respective samples. Four studies employed variations of cognitive behavioural therapy (CBT) to address symptoms of anxiety, depression and post-traumatic stress (Cooley-Strickland et al. 2011; Stewart et al. 2021; Tandon et al. 2015; Waldrop and de Arellano 2004). Salloum and Overstreet (2012) combined CBT and psychodynamic interventions, such as trauma narrative processing that focuses exclusively on grief in a group therapy modality. Thomas et al. (2021) evaluated an intervention adapted from Coping Power in the City (CPIC), an evidence-based program designed to strengthen coping skills among African American male youth.

Two studies explicitly incorporated cultural adaptations to CBT (Stewart et al. 2021; Thomas et al. 2021). Stewart et al. (2021) modified trauma-focused cognitive behavioural therapy (TF-CBT) to include racial socialization messages, cultural values, religious beliefs and discussions of racial barriers throughout the treatment. Thomas et al. (2021) adapted CPIC through collaboration with experts in adolescent development, racial socialization and culturally responsive care, as well as focus groups with high school students and school counsellors to enhance relevance and accessibility. The intervention included multiple components, including engagement with parents and school personnel.

Across studies, interventions comprised 10 or more sessions, with an average of 14.8 sessions. All interventions were delivered by trained clinical professionals, including social workers, counsellors and psychologists. No clear differences in reported intervention outcomes were associated with provider credentials.

3.2.3 | Intervention Outcomes

Anxiety and depression were the primary outcomes assessed in four of the six studies (Cooley-Strickland et al. 2011; Tandon et al. 2015; Thomas et al. 2021; Waldrop and de Arellano 2004), while two studies focused specifically on traumatic stress outcomes (Stewart et al. 2021; Waldrop and de Arellano 2004) (see Table 1). Salloum and Overstreet (2012) assessed depression and traumatic stress outcomes.

All studies employed well-established, validated measures to assess symptoms. Disorder-specific instruments included the Center for Epidemiological Studies Depression Scale (CED-S), Child Behaviour Checklist (CBCL), and Mood and Feelings Questionnaire-Child Version (MFQ-C) for depression (Salloum and Overstreet 2012; Tandon et al. 2015); the Revised Children's Manifest Anxiety Scale (RCMAS) for anxiety (Cooley-Strickland et al. 2011); the Trauma Symptom Checklist for Young Children (TSCYC) (Waldrop and de Arellano 2004); and the University of California, Los Angeles Post Traumatic Stress Disorder Reaction Index (UCLA-PTSD-RI) for trauma (Salloum and Overstreet 2012; Stewart et al. 2021). One study used the Behaviour Assessment System for Children-2 (BASC-2), a comprehensive measure of emotional and behavioural functioning, to assess changes in anxiety and depression symptoms (Thomas et al. 2021).

Four studies reported statistically significant reductions in anxiety and/or depressive symptoms among African American male participants following CBT-based interventions (Cooley-Strickland et al. 2011; Stewart et al. 2021; Tandon et al. 2015; Waldrop and de Arellano 2004). In addition, Stewart et al. (2021) reported significant reductions in post-traumatic stress symptoms using a culturally adapted CBT approach in a multiple case study. Salloum and Overstreet (2012) did not report gender specific results, but they reported statistically significant reductions in PTSD and depressive symptomology in their entire sample, with 76%–88% of participants no longer meeting criteria for

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TABLE 1 | Overview of the study characteristics, interventions, outcomes and key findings of the included studies.

Study	Sample and demographics	Intervention	Number of sessions	Cultural adaptation	Primary outcomes	Key findings
Cooley-Strickland et al. (2011)	N = 98; Mixed gender; ≥ 50% male; ≥ 95% African American; mean age: 9 years; youth at risk	Cognitive Behavioural Therapy (CBT)	13	No	Anxiety, depression	Reduced anxiety and depressive symptoms
Salloum and Overstreet (2012)	N = 72; Mixed gender; ≥ 50% male; ≥ 95% African American; mean age: 9.6; trauma exposed	Grief and Trauma Intervention-Coping skills (GTI-C), Grief and Trauma Intervention-Coping skills and narrative construction (GTI-CN), group-based	10	No	Depression, PTSD, traumatic grief	Symptom reductions across domains
Stewart et al. (2021)	N = 1; male; African American; age: 7 years; trauma-exposed	Trauma Focused-Cognitive Behavioural Therapy (TF-CBT), telehealth	16	Yes	PTSD, anxiety, depression	Symptom reductions across domains
Tandon et al. (2015)	N = 782; Mixed gender; ≥ 50% male; ≥ 95% African American; mean age: 19 years; housing instability	Cognitive Behavioural Therapy (CBT)	12	No	Depression	Reduced depressive symptoms
Thomas et al. (2021)	N = 514; ≥ 50% male; ≥ 95% African American; mean age: 14 years; violence exposure	Coping Power In the City (CPIC), group-based	16	Yes	Anxiety, depression	Reduced anxiety and depressive symptoms
Waldrop and de Arellano (2004)	N = 1; male; African American; age: 5 years; trauma-exposed	Cognitive Behavioural Therapy (CBT)	20	No	PTSD, anxiety, depression	Symptom reductions across domains

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PTSD and 77%–100% of participants no longer meeting criteria for depression.

4 | Discussion

The purpose of this comprehensive review was to identify and examine intervention studies developed and tested for African American male youth experiencing symptoms of anxiety, depression or traumatic stress. We sought to map the characteristics of existing interventions, including therapeutic approaches, implementation strategies and reported outcomes, to better understand the current state of the evidence. Two authors (REB and SH) bring over 20 years of combined clinical experience working with African American youth and are familiar with diagnostic and treatment commonly applied to African American male youth. SH has extensive experience providing therapy and psychological assessment services to children, adolescents and adults within inpatient, residential, outpatient and school settings. She provides supervision to graduate trainees and mental health professionals with the goal of creating equitable access to quality mental health services. REB integrates her work as a clinician with her scholarship, where she aims to develop interventions to support positive identity development of African American boys and adolescents and mitigate the traumatic stress symptomology course for African American youth impacted by gun violence. These endeavours require an understanding of the treatment landscape in the interest of developing interventions that build on established efficacious treatment models and address gaps where they exist. Therefore, this review was undertaken to systematically assess the empirical literature beyond clinical observation and experience.

Across the review process, only six intervention studies published between 2004 and 2021 met the inclusion criteria. All six studies employed some version of CBT, with an average of approximately 15 sessions. Most interventions were delivered in individual therapy formats (Stewart et al. 2021; Tandon et al. 2015; Waldrop and de Arellano 2004), while three studies implemented more multicomponent, group, or contextualized approaches that extended beyond individual treatment (Cooley-Strickland et al. 2011; Salloum and Overstreet 2012; Thomas et al. 2021). Only two studies specifically adapted CBT to address the cultural and contextual experiences of African American boys (Stewart et al. 2021; Thomas et al. 2021).

Although all included studies reported reductions in anxiety, depression or traumatic stress symptoms, the small number of studies, heterogeneity in sample size and design and limited use of culturally tailored interventions preclude conclusions about intervention superiority or generalizability. Instead, the central finding of this comprehensive review is the striking paucity of clinical intervention research and the meaningful implications for practice, as clinicians are often required to rely on limited evidence or extrapolate from studies conducted with other populations to treat their African American male youth clients. The sections that follow consider the implications of this evidence gap and offer practice-informed considerations grounded in the available literature.

4.1 | Effectiveness of CBT in Included Studies

CBT and its evidence-based variants were the preferred treatment interventions used across all studies included in this comprehensive review (Cooley-Strickland et al. 2011; Salloum and Overstreet 2012; Stewart et al. 2021; Tandon et al. 2015; Thomas et al. 2021; Waldrop and de Arellano 2004). Two of the six studies employed single-case designs involving one African American male participant, which limits the generalizability of their findings (Stewart et al. 2021; Waldrop and de Arellano 2004). Despite this limitation, each study reported reductions in symptoms of anxiety, depression or traumatic stress following intervention delivery. These findings suggest that CBT-based approaches may be promising for addressing internalizing symptoms among African American male youth; however, the small number of studies, wide variability in sample size, and heterogeneity in intervention design preclude definitive conclusions regarding treatment effectiveness. The unexpectedly limited number of eligible studies highlights the need to examine patterns in the broader intervention literature from which studies were excluded.

4.2 | Prevalence and Focus of the Excluded Studies

This comprehensive review anticipated identifying disparities in the number of intervention studies addressing internalizing disorders among African American boys; however, the magnitude of this gap exceeded expectations. Of the 8651 studies excluded at the title and abstract screening stage, the majority were outcome-focused rather than intervention-focused. Among the 36 studies excluded during full-text review, exclusions were primarily due to ineligible populations ($n = 17$), outcomes that did not align with the review's inclusion criteria ($n = 6$), or wrong study type ($n = 3$) (see Supporting Information S3).

A substantial proportion of excluded studies focused on externalizing disorders (e.g., aggression, disruptive behaviours, and attention deficit hyperactivity disorder), risky sexual behaviours and obesity. Intervention studies identified during the screening phase reflected similar priorities, with these three outcome domains accounting for approximately 60% of the 8693 unique records reviewed. Externalizing disorders and risky sexual behaviours appeared in nearly equal proportions, with externalizing behaviour outcomes most frequently represented. Although these studies were excluded from formal analysis, documenting this disproportionate focus is important, as it underscores prevailing research priorities and helps contextualize the limited attention given to interventions targeting internalizing symptoms among African American boys.

4.3 | Diagnostic Screening and Assessment Recommendations

The importance of culturally responsive diagnosis and treatment for individuals from diverse cultural backgrounds has been widely recognized as essential to reducing misdiagnosis and improving treatment outcomes (Ballentine 2019; Casimir and Morrison 1993; Forehand and Kotchick 1996; McLaughlin et al. 2007; McNeil et al. 2002; Robinson and Clark 2017;

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Worthington 1992). Findings from this review underscore the consequences of misdiagnosing African American boys and young men who may have internalizing disorders, such as anxiety, depression or PTSD, as having externalizing disorders like oppositional defiant or conduct disorder. Although this review did not directly evaluate diagnostic tools, the limited intervention literature highlights the need for greater attention to culturally informed screening and assessment practices as a foundational component of effective treatment.

Developing and evaluating interventions that adequately address the mental health needs of African American boys requires attention to cultural history, daily lived experiences and contextual stressors prior to treatment entry. Existing theoretical and clinical scholarship demonstrates that race and ethnicity can influence a child's symptom presentation, coping mechanisms and emotional responses, including anger, fear, depression and anxiety (Ecklund and Johnson 2007a; Gibbs and Huang 1989; McLaughlin et al. 2007; McNeil et al. 2002). Consequently, culturally responsive diagnostic evaluations and intake assessments are critical for reducing misclassification and informing appropriate intervention planning.

The American Psychological Association (2023) defines cultural competence as the integration of culture-specific knowledge, ongoing cultural self-assessments, recognition of within- and between-group differences and the application of these insights to professional practice. Practitioners working with Black male youth and young men have an ethical responsibility to develop cross-cultural competence to inform clinical interventions that promote healthy functioning within the appropriate cultural context (McPhatter 1999). Drawing on guidelines from the American Psychiatric Association, Ecklund and Johnson (2007b) recommend that practitioners develop a cultural formulation during their initial encounter with a child. This includes considering the child's cultural identity, cultural explanations of illness, cultural factors related to psychosocial environment and functioning and cultural dynamics of the clinician–patient relationship. They further suggest initiating assessments with explicit acknowledgment of the importance of understanding family history, parenting practices, school and community contexts and other social environments relevant to the child's experience (Ecklund and Johnson 2007a). Consultation of professional guidelines and culturally responsive assessment frameworks may therefore support more accurate identification of internalizing symptoms and inform intervention selection for African American boys and young men.

In addition to building strong rapport and creating a safe space for families to share their stories, practitioners benefit from training, supervision and consultation that support the use of multiple data sources to inform diagnostic decision-making. Accurately identifying internalizing symptoms and co-occurring conditions can be particularly challenging when working with children who have complex developmental and trauma histories. Given documented cultural bias in standardized assessment tools (Fadus et al. 2020; Reynolds and Suzuki 2012; Valencia and Suzuki 2001) as well as the potential for bias in practitioner observation, rating and clinical judgement (Baglivio et al. 2017; Mandell et al. 2007; Minsky et al. 2003), greater attention to diagnostic processes is warranted to reduce racial disparities in mental health assessment. Practitioners involved in diagnosis and supervision are encouraged to consider how experiences of racism shape Black children's symptom presentation and behavioural expression (Ballentine 2019) and to explore both overt and covert trauma histories when assessing Black male youth and young men (Armstrong 2017; Baldridge et al. 2011).

Failing to account for the complexity and comorbidity of mental health concerns among Black male youth and young men has been associated with adverse outcomes across multiple domains, including long-term health, academic achievement, community participation and increased suicidality (Ballentine 2019; Congressional Black Caucus 2020; Fadus et al. 2019; McLaughlin et al. 2007). A report from the Congressional Black Caucus (2020) documented a 73% increase in self-reported suicide attempts among Black male adolescents over a 25-year period, despite concurrent declines in reported suicidal ideation and planning, suggesting a troubling pattern of movement from distress directly to attempts. One factor, likely, contributing to this trend is reduced access to timely treatment for depression, a well-established risk factor for suicide. Depressive symptoms in children and adolescents may reflect the cumulative effects of genetic predisposition, trauma, undiagnosed or co-occurring neurodevelopmental disorders (e.g., autism, attention deficit hyperactivity disorder [ADHD] or learning disorders), racism and feelings of inadequacy. Understanding these intersecting risk factors and the varied ways in which symptoms may manifest is therefore essential for informing appropriate interventions and mitigating risk.

Comprehensive diagnostic intake and assessment processes represent an important foundation for identifying appropriate intervention pathways for Black male youth and young men. Beyond standard diagnostic questioning, practitioners may consider incorporating attention to environmental stressors, family changes and losses and individuals' prior experiences with educational, social service, healthcare and mental health systems, as these contexts can influence symptom presentation and be reported during intake. Addressing structural inequities, stigma and historical mistrust of healthcare systems remains a critical consideration in reducing barriers to care and supporting sustained engagement in treatment for Black male youth and young men (Congressional Black Caucus 2020).

4.4 | Clinical Treatment Recommendations

As the evidence base continues to develop, future intervention research may clarify which specific evidence-based treatments are most effective for Black male youth experiencing depressive, anxiety, or traumatic stress symptoms. In the interim, youth and families may often access commonly available services, including outpatient psychotherapy, school-based mental health services and evidence-based group interventions. Drawing on the findings of this review and the broader clinical literature, the considerations below highlight practice-informed approaches for working with this population.

4.4.1 | Individual and Family Outpatient Services

Mental health services delivered in clinics, doctors' offices and community mental health centers are commonly classified as

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outpatient care (American Psychological Association 2018). Individual and family outpatient therapy represents one of the most common and frequently accessed forms of mental health treatment for children and adolescents. Because referrals to outpatient services often centre on disruptive behaviour disorders, such as oppositional defiant disorder, attention-deficit hyperactivity disorder and conduct disorder, and these conditions constitute a large portion of referrals to mental health clinics (McNeil et al. 2002; Wells and Forehand 1985), clinicians may benefit from carefully reviewing diagnostic impressions before initiating treatment. Attention to diagnostic accuracy may help reduce the risk of narrowing treatment options for ethnically minoritized youth (Fadus et al. 2020).

During initial encounters and diagnostic intake, clinicians may consider emphasizing the relevance of cultural context in the child's or adolescent's life and explicitly acknowledging its importance to families when establishing the therapeutic relationship. Even when concerns centre on externalizing behaviours, comprehensive assessment processes that address potential comorbidities and incorporate multiple sources of information can support the identification of co-occurring internalizing symptoms. Outpatient settings may also provide opportunities to educate and empower families by reframing symptoms, behaviours, and diagnoses through a strengths-based and culturally responsive lens.

Adjacent to outpatient mental health treatment, African American male youth can access school- and community-based programs that focus on other outcomes such as academic achievement, emotion regulation, identity development and general well-being. Programs that utilize hip hop, historical cultural education and resilience, positive Black masculine development frameworks and critical consciousness and civic engagement frameworks are not primarily designed to address internalizing symptoms. However, they may indirectly reduce such symptoms by targeting outcomes shaped by multilevel contexts, including structural racism, environmental stressors and interpersonal traumas that also predict the development of internalizing symptoms (Carey et al. 2025; Gale et al. 2024; Nelson 2016; Washington 2021).

4.4.2 | Evidence-Based Group Interventions

Standardized cognitive behavioural interventions are widely recommended for addressing anxiety, depression and trauma in children and adolescents (Cooley-Strickland et al. 2011; Stewart et al. 2021; Tandon et al. 2015; Waldrop and de Arellano 2004). However, existing research suggests that these approaches often require adaptation to ensure relevance and effectiveness for racially and ethnically diverse youth (Abney 2002; Comas-Díaz 1989; Fontes and Thomas 1996). Ongoing efforts to strengthen evidence-based group interventions may benefit from greater inclusion of diverse samples and from the systematic review of Black male youth-affirming frameworks, the collection of feedback from youth and families on intervention structure, accessibility and cultural relevance (Carey et al. 2022; Jones and Neblett 2016; Sidwell et al. 2025; Wint et al. 2022).

5 | Conclusion

This comprehensive review highlights the urgent need for culturally responsive clinical interventions targeting internalizing symptoms among African American boys. Despite the rise in mental health challenges, including anxiety, depression and traumatic stress, clinical intervention research remains limited (Blumberg et al. 2015; DeAngelis 2021; McKenzie et al. 2022). CBT shows promise, yet the lack of culturally tailored approaches and the small number of studies limit definitive conclusions. To address these gaps, future research should prioritize developing interventions that integrate cultural and contextual factors, ensuring they are relevant and effective for this population. Clinicians must adopt culturally competent diagnostic and treatment practices to mitigate misdiagnosis and improve outcomes. By advancing these efforts, we can better support the mental health and well-being of African American male youth.

Author Contributions

R.E.B. and N.T. conceptualized the study and designed the protocol. N.T. conducted database searches. R.E.B., S.H.W. and C.U.O. screened articles for inclusion in the review. R.E.B., S.H.W. and C.U.O. extracted data for the included studies. R.E.B., S.H.W., N.T., C.U.O. and N.M.W. conducted the analysis and drafted specific sections of the manuscript. All authors contributed to this work. All authors read, edited and approved the final manuscript. The opinions stated in this article are solely the responsibility of the authors and may not reflect the views, choices or policies of their associated organizations.

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Ethics Statement

Comprehensive reviews analyse publicly available data from previously published studies and do not involve direct interaction with human participants or the use of personally identifiable information. Therefore, ethical approval is not needed.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

The data that support the findings of this study are openly available in OSF at https://osf.io/, reference number 10.17605/OSF.IO/42YVC.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section. **Data S1:** Supplemental Material S1: Search Terms Supplemental Material S2: Search Strategies Supplemental Material S3: List of Excluded Studies with Reasons **Data S2:** Supporting Information

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