Practicing Multiculturalism, 2004, Pearson Education

8

Counseling and Psychotherapy with African American Clients

Leonie J. Brooks
Towson University

Deborah G. Haskins
Loyola College in Maryland

Judith V. Kehe
Community College of Baltimore County–Essex Campus and Loyola College in Maryland

Descriptive Information

A clear understanding of the term *African American* is a necessary prerequisite for culturally competent counseling and psychotherapy with this population. Historically, the term has been used to describe those persons of African descent who were born in the United States, and who may have experienced or inherited a history of slavery and oppression. The authors would like to include in this category of *African Americans* those persons who have immigrated to the United States and who choose the term "African American" because it best fits their group identity. Such persons of color include those from the African Diaspora such as African countries, the West Indies, the Caribbean, and South America who do not classify themselves as Caucasian, Asian, Hispanic, or Native American. Such an inclusion of persons from diverse ethnic and cultural backgrounds (whose forced or voluntary displacement from their homeland brought them to the New World) fosters a more comprehensive understanding of the term *African American*. And while this inclusion creates the tendency towards generalization, the authors offer useful strategies and insights for

Practicing Multiculturalism, 2004, Pearson Education

innovative practices that value and appreciate multiculturalism. Additionally, the authors bring their unique perspectives: an African American who was born in the USA and two immigrants of African descent from the Caribbean—one having entered the high school system on arrival and the other having entered the workforce.

Demographic information on "African Americans" has traditionally classified them as "Blacks," and these two terms are often used interchangeably in the literature. White and Parham (1990) suggest that the use of "Black" and "African American" refer, respectively, to the experience of blackness in a white supremacy environment and the endorsement of cultural roots that can be traced back to Africa. The experience of being "Black" or "African American," therefore, must be understood within the context of an individual's experiences. For a therapist, it is important to keep in mind that either term can create conflicts for clients based on their personal stories, their racial identity development, and the sociopolitical context of their experiences, especially in the context of racism, classism, discrimination, and prejudice. Some clients may prefer the term *African American* over *Black* or *Negro* since more negative stereotypes have been attributed to the latter two, while others may indicate a preference for either of the latter two based on their racial identity development and their personal experiences. There are also age and generational differences in the preference for these terms. The younger often choose *African American,* while the older prefer the term *Black,* and a preference for *Black* is strongest among college-educated, affluent, and executive households, as well as in rural areas and in the South (Edmonson, 1993). In addition, Blacks who are immigrants may not readily identify with being "African American" or with having a minority status, making salient the need to differentiate among the African American population. As Watkins-Duncan (1992, p. 453) noted, it is important for psychotherapists to know if their clients consider themselves American Black, European Black, Caribbean Black, Southern Black, and so on. As will be emphasized in this chapter, African Americans are a very diverse group with respect to skin color, nationality, education, language, socioeconomic status, spirituality, faith denomination, sexual orientation, heritage, and geographic location of birth.

According to the U.S. Census Bureau information, there are 35.1 million Blacks in the United States, comprising 13 percent of the total population; most Blacks reside in the South (55 percent), with 19 percent living in the Northeast, 18 percent in the Midwest and 8 percent in the West; Blacks are more likely than non-Hispanic Whites to live in metropolitan areas (McKinnon & Humes, 2000). Cities with the largest African American population are New York City, Houston, Los Angeles, Philadelphia, Washington D.C., Detroit, New Orleans, Baltimore, and Memphis, with over 50 percent of the African American population found in the latter five cities (U.S. Census Bureau, 1990).

Based on the 1999 Current Population Survey (CPS), McKinnon and Humes (2000) have indicated that even though the life expectancy of Blacks (African Americans) has increased, their median age continues to be about 6 years younger than the non-Hispanic White population, with 33 percent of the Black population falling under age 18 as compared to 24 percent of the non-Hispanic White population. Black families are also larger than their non-Hispanic White counterparts in that married couples are more likely to have three or more children (20 percent and 12 percent, respectively). The numbers of Blacks employed in professional jobs such as lawyers, doctors, and engineers have also increased

Practicing Multiculturalism, 2004, Pearson Education

over the past several decades. However, Blacks participate in the labor force at lower rates than non-Hispanic Whites, and Black men are less likely than non-Hispanic White men to be employed in managerial and professional jobs. Similar proportions of Black men and women (25 years and over) are at least high school graduates, but Black women are more likely to have completed a bachelor's degree (McKinnon & Humes, 2000).

McKinnon and Humes (2000) compared Blacks and non-Hispanic Whites on poverty and unemployment rates. In 1998, the poverty rate, which was 13 percent for the overall population, was 26 percent for Blacks and 8 percent for non-Hispanic Whites. Among all children under age 18, the poverty rate was 19 percent, but for Blacks, this rate was three times as high (37 percent) when compared to non-Hispanic White children (11 percent). In March 1999, the employment rate for Blacks was more than twice that of non-Hispanic Whites, and while the median income of African American married couples is increasing, African American married couples are less likely than their non-Hispanic White counterparts to have an annual income of $50,000 or more (28 percent as compared to 52 percent). In sum, even though improvements in the socioeconomic situations of some African Americans have been made in recent years, vast inequities still exist. These inequities and the history of injustices that shaped them provide a context from which to understand cultural conflicts that can arise in counseling and psychotherapy.

Key Cultural Conflicts Encountered When Working with African Americans

There are several important cultural conflicts that therapists can consider when conducting psychotherapy with African Americans. These cultural conflicts are likely to influence the willingness of African Americans to seek help, the interpersonal relationship between the therapist and the client, and also the process of psychotherapy. African Americans as a group have a long history of traumatic events including slavery, racism, poverty, and a host of other individual and social problems. The most blatant indicators of the cumulative effects of trauma are evidenced in health, income, education, and occupational success (Dana, 1993). Thus, African Americans' experiences with slavery and racism in America continue to impact their daily survival, their intrapersonal and interpersonal behavior, and their willingness to seek help from others.

Acknowledgment of Oppression

Therapists will be most effective if they develop a personal awareness of how oppressive experiences, like racism and discrimination, influence help-seeking behaviors and overall psychological functioning. As Cook and Wiley (2000) and Helms and Cook (1999) have stated, many African Americans will share their experiences of oppression in psychotherapy. Therapists who have limited knowledge of the history of racism and oppression among African Americans or those who have not developed increased cultural empathy to validate an African American's experience could, unknowingly, perpetuate conflicts during the therapeutic process.

Practicing Multiculturalism, 2004, Pearson Education

Impact of External Coping Resources

Second, although oppressive events have been significant and often insidious, African Americans possess the resiliency to cope, and they have learned to rely on their own resources instead of seeking outside help. Several researchers (Baldwin & Hopkins, 1990; Boyd-Franklin, 1989; Cook & Wiley, 2000; Nobles, 1991) have discussed the value African Americans place on religion and spirituality and the influence of these factors on clients' ability to solve seemingly insurmountable problems. Therefore, another cultural conflict may involve "selling" psychotherapy as an optimal or useful coping strategy, since African Americans have traditionally used religious, spiritual, and personal resources for healing internal and external problems. Excluding spirituality and religion from the assessment process can, therefore, be a source of conflict for clients.

Differences in Worldview

Third, Baldwin and Hopkins (1990) have stated that African Americans develop a particular worldview that emphasizes beliefs often derived from their racial and cultural experiences. This worldview includes their assumptions and guiding beliefs about life existence (Cook & Wiley, 2000; Helms & Cook, 1999; Jackson & Meadows, 1991). For example, one African American worldview places a dominant value on harmony with nature, emphasizing the search for balance or harmony. Harmony and balance are achieved through survival of the corporate whole, such as the family, community, and nation, versus an emphasis on survival of the individual (Baldwin & Hopkins, 1990). Since this African American worldview stresses communal harmony and emphasizes interdependence, another key cultural conflict may arise if psychotherapy focuses primarily on the client's individual needs instead of the client's connectedness with community (i.e., family and support networks such as friends, church, and other organizations). Since many of the traditional psychotherapy models stress individualism versus collectivism (Helms & Cook, 1999; McGoldrick, Giordano, & Pearce, 1996; Sue & Sue, 1999), therapists working with African Americans can be more effective if they validate an African American's interdependence with others when conceptualizing the client's presenting problem and its resolution.

Racial Identity Development

Racial identity is a fourth factor that has an impact on the African American's willingness to seek help the development of a therapeutic relationship, and participation in the psychotherapy process. Mental health professionals who do not become aware of their own racial identity and recognize the African American's racial identity may encounter conflicts when attempting to provide therapeutic services (Cook & Wiley, 2000; Helms & Cook, 1999; Pierce & Pierce, 1984; Sue & Sue, 1999).

One of the first racial identity models was the Cross (1971) Nigresence Model. *Nigresence* is defined as the psychology of becoming Black (Cross, Parham, & Helms, 1998). The 1971 Cross model included five stages: the Preencounter stage, which describes the old identity or the identity to be changed; the Encounter stage, which defines the events and experiences causing an individual to feel the need for change; the Immersion-Emersion

Practicing Multiculturalism, 2004, Pearson Education

stage, which illustrates the transition between the old and the developing identities; and two final stages, Internalization and Internalization-Commitment, which identify behaviors, attitudes, and psychological development that accompany habituation to the new identity (p. 96). To illustrate these stages the following examples are provided:

Preencounter Stage. An African American woman is in her first week at a new office job. Her boss says, "You know I am so impressed with your work. The only African American woman working for me has been my housekeeper, and she is so efficient! I never have to worry about my house being clean." The African American employee replies, "Thank you so much for the compliment. It is really important for me to do my work accurately." The employee does not appear conscious of her employer's stereotyped images of African Americans as working solely in manual labor jobs.

Encounter Stage. An African American child moves to a suburban neighborhood from the city. His old neighborhood was primarily African American, but the new neighborhood is primarily European American. He forms many friends in the new neighborhood, but one day one of the children tells him, "My father said I cannot play with you because you are Black." The African American child never had anyone in his old neighborhood say this to him before. Previously, the boy down the street did not play with him because he did not have the toy he wanted. The African American child is hurt and confused, and he asks his parents what is wrong with being Black. This little boy has just had an Encounter stage experience, facing opposition and racism for the first time. His parents' ability to help him understand the incident and their ability to affirm his Blackness will potentially influence his progression to the next Nigresence stage.

Immersion-Emersion Stage. An African American employee notices that most of her fellow employees question her attachment to African culture. They question her placement of African artifacts in her office. She is aware that when she was younger she was not particularly familiar with her African heritage, but as she matured her ancestral heritage became more important. At a recent Diversity Awareness Training day, employees were encouraged to integrate their rich multicultural experiences in the workplace. She decided that it was important to share her African heritage even at work.

During the Immersion stage, the person immerses him- or herself in the world of Blackness. The person attends political or cultural meetings that focus on Black issues, joins new organizations, and incorporates more Afrocentric values (Ponterotto et al., 1995). The second part of the Immersion-Emersion stage is that the person emerges from the emotionality of the Nigresence identity and begins to "level off" and feel in control of his or her emotions and intellect about the developing Blackness.

Internalization Stage. The person at this stage has naturally incorporated Blackness in everyday life, which also serves as a psychological buffer against racism and other challenges. A range of racial and ethnic diversity in the world is recognized, and the person internalizes an identity wherein Blackness becomes one of several possible bicultural or multicultural identities. This internalized identity also makes transactions with people, cultures, and human experiences beyond solely a Black experience (Ponterotto et al., 1995).

Practicing Multiculturalism, 2004, Pearson Education

Internalization-Commitment Stage. The African American is committed to a lifetime of developing a Black identity and personal action. The individual may devote time and energy to helping African American children in the community learn about African culture. This person may mentor other African American children or become an advocate for civil rights with the National Association for the Advancement of Colored People (NAACP).

Acculturation

Finally, the process of acculturation can also be a source of conflict in the therapy process. Berry and Annis (1974) and Brislin, Lonner, and Thorndike (1973) proposed that acculturation is a multidimensional psychosocial phenomenon reflected in psychological changes that occur in individuals encountering a new culture. Examples of psychological changes could include culture shock, isolation from familiar cultural experiences, communication difficulties, and lack of support systems (Winkelman, 1994). Berry and Annis (1974) have provided a model for understanding the stress associated with acculturation. In this model, clients can experience stress as a result of their efforts to negotiate their cultural identity in a new culture. Racial identity issues sometimes compound issues of acculturation. For example, a Black immigrant from the Caribbean, whose primary identity might have been based on national or geographic origin, will be confronted with being defined solely by his or her race upon arrival in the United States. In addition to the stress of acculturation, this immigrant will have to deal with the issue of classifying self as an African American, a foreign concept to one who previously considered self as West Indian or Caribbean. Therapists should be cognizant of the psychological consequences of acculturation, as well as its interface with racial identity issues.

Contextual Issues

As emphasized throughout this book, effective multicultural counseling and psychotherapy considers the multiple contexts of an individual client. Although the following sections do not cover every aspect of a client's experience (see Hays, 1996 for a comprehensive framework), they serve as an overview of several important contextual issues that should be considered when working with African American clients.

Family Dynamics

There is a range of family constellations among African American families, including multigenerational and single parent families. Estimates from the Census Bureau indicate that in 2001 approximately 48 percent of the 8.7 million African American families were married-couple families (U.S. Census Bureau, 2001). The number of Black households, especially female-headed Black households, has increased since 1980, with approximately 45 percent of Black families maintained by women with no spouse present in 1999 (McKinnon & Humes, 2000). While this increase may be partly due to the increased rates of divorce and separation in the population at large, it could also be due to the national

trend of women and men choosing to live alone. In addition, African Americans have a higher rate of choosing not to marry than do European Americans (Boyd-Franklin, 1989).

According to Boyd-Franklin (1989), African American families are extremely diverse in their values, characteristics, and lifestyles, due to a number of factors including acculturation, geographic origin, socioeconomic status (SES), education, and religious background. Sexual orientation and history of colonization could be added to this list. Historically, families have included extended kinship networks that extend beyond the traditional bloodlines to include non-blood relations described as uncles, aunts, big mamas, older brothers and sisters, deacons, preachers, etc. (McGoldrick et al., 1996). This practice of having strong extended kinship bonds within African American families can be traced back to the time when their ancestors were brought from Africa to the United States and the Caribbean as slaves. While many families were broken up during the practice of slavery, many slaves established new family units including non-blood relatives. Immediate and extended family members form interdependent relationships, pool resources, and share in many tasks, which include rearing children and caring for the elderly. It is not unusual for extended family members to step in and raise other family members' children if parents are unable to or if extended family members can provide a better life (Hines & Boyd-Franklin, 1996). Many African American families have also included the church as part of their extended family network, with church members assisting in rearing the children and in preparing and supporting them for adulthood (Cook & Wiley, 2000). In the past, many young adults were assisted in pursuing higher education by their home church through scholarships and other fundraisers.

Another common dynamic within African American families is the parental–child system (Hines & Boyd-Franklin, 1996). In this system, an older child is selected or volunteers to assist with parental responsibilities for younger siblings because parents work or because there are many children in the family (p. 72). When working with African American families, it is important for the therapist to be flexible in his or her definition of family. Asking clients whom they include in their designation of family should be a part of the assessment process.

Gender Issues

Gender influences therapy with the African American population. Both African American men and African women were subjected to the trauma and devastation of slavery. Both were exploited, families were torn apart, and women were often, out of necessity, left primarily responsible for taking care of and providing for their children when the children themselves were not sold away. While many men and women have created and sustained healthy families, this legacy of broken families and egalitarian gender roles (where both men and women are heads of households and providers) has continued, due in part to ongoing discrimination against African American men and women in the larger society.

As with many other ethnic groups, the identity of African American men continues to be linked to their ability to provide for their families (Abreu, Goodyear, Campos, & Newcomb, 2000). "Success in being a provider, however, is often limited by discrimination" (McGoldrick et al., 1996, p. 69). According to Franklin (1996), this limitation may cause many African American men to feel marginalized and invisible because of the seemingly

Practicing Multiculturalism, 2004, Pearson Education

insurmountable obstacles they face when trying to provide for their families. While African American men are diverse in their SES, educational achievement, principles, and lifestyles (Lee & Bailey, 1997), they have had to deal with the issue of racism, which can have a deleterious impact on their overall mental health and function. Although the reaction to racism varies greatly among African American men, the difficulty in fulfilling their traditional masculine role has led to a number of problems including difficulties with anger, frustration, low self-esteem, and depression (Gary, 1985; Washington, 1987). Despite these challenges, African American men, like most other men, have traditionally been reluctant to enter therapy (Lee & Bailey, 1997). It is very important for therapists working with this group to take time to develop rapport by being respectful, genuine, and open to being questioned, remaining sensitive to issues of racism and discrimination and to the unique challenges faced by African American men in America.

Historically, African American women have generally been perceived as the strength or backbone of their families and of their communities. Relationships between African American men and women have been described as more egalitarian than those of other ethnic groups due in part to the expectation that women will be participating in the workforce. However, these egalitarian relationships still function within the context of a patriarchal society (Hines & Boyd-Franklin, 1989, p. 70). Many male-female relationships for Caribbean- and African-born Blacks, in particular, tend to reflect more traditional and stereotypical gender roles, with males seen as authority figures and providers and women viewed as responsible for the emotional well-being and nurturing of their families (Gopaul-McNicol, 1993; Nwadiroa, 1995). Therefore, it is important for a therapist to be sensitive to gender role and power dynamics issues when working with African American families.

Spirituality and Religious Issues

Within the United States, African Americans belong to a variety of religious denominations (see Cook & Wiley, 2000). However, the literature often uses the term "the Black Church" to refer to the many denominations whose membership is predominantly African American. Historically, religion and the Black Church have provided authentic validation of the African American's cultural and racial identity and have contributed to their identity formation. Cook and Wiley (2000) stated that it was in the Black Church that African Americans could escape the rejection often imposed by society and find solace and acceptance in their religious experience. Through their church many African Americans learned to read, hold leadership positions, access housing and financial resources, and find increased social supports.

Religion and spiritual experiences have traditionally been ignored in the field of psychology. However, during the last decade many codes of ethics within psychology, counseling, and social work have mandated that members of the professions integrate religion and spirituality to address cultural diversity needs within mental health service delivery (American Counseling Association, 1995; American Psychological Association, 1992, 1993; National Association of Social Workers, 1993). Social and human service fields are learning to be sensitive to religious and spiritual diversity. Many persons of African descent validate the importance of religion and spirituality in their lives. Cook and Wiley

Practicing Multiculturalism, 2004, Pearson Education

(2000) recommend that therapists need to assess whether these clients are using religion or spirituality in positive or negative ways.

Helms and Cook (1999) provided a clear understanding of religious spirituality. The authors stated that while many religious practices focus on the supernatural, for purposes of their discussion they focused on the relationship that members of a culture have with their "God figure." The authors explained that various religions propose that persons should rely on a "higher (or universal) spiritual power" to direct them in their lives and that through prayer and other worship techniques, persons can "call upon" this higher power for guidance and for emotional strength when problems arise. Psychological distress is considered to be related to an individual's failure to follow the edicts or life process of his or her religion; therefore, the healing process involves calling on the higher power to heal believers of their distress, and religious helpers assist in this process through prayer and instructions for devout living (p. 259). It is important, therefore, for therapists to understand how clients may call on their "higher power."

Smith (1981) discussed the positive contribution of religion in the mental health of African Americans. This author maintained that religion is one of the most vital aspects of culture that African Americans have retained over the years and that African Americans use religion and spirituality for mental health and survival. Smith discussed Grier and Cobb's (1968) appraisal of the religion–mental health link in African American communities, describing how mental health and religious entities can develop partnerships for African Americans in healing psychological disturbances. Smith also emphasized that African Americans will be further alienated in American society if they are not allowed to use the creative and spiritual tools which often define their existence. Finally, Smith also pointed out that psychotherapy is often not available or helpful to the poor, uneducated, and African American populations. As a result, many African Americans have found that identifying with and participating in the churches is more affirming of mental health than psychotherapy. He advocated the need for mental health professionals to recognize the Black Church as a mental health resource and noted that in traditional African societies a person's mental health issues were not separated from the individual's spiritual well-being. In African culture, spirit is recognized to be "in everything and everywhere" (Mbiti, 1991). On the other hand, Grier and Cobbs' (1968) model of religion considered Black religions to be pathological and detrimental to the mental health of African Americans. These authors believed that African Americans cover up rage and anger during the process of seeking solace through religion, and this cover-up causes additional psychological damage. Grier and Cobbs stated that African Americans must accept certain psychological truths, including harsh realities of racism, poverty, and other social ills.

It is true that some African Americans, like some members of other racial and ethnic groups, may use religion to the extent that they decrease personal control and responsibility, for example, using the Bible to substantiate extreme physical abuse with the scripture "spare the rod and spoil the child." However, it is important to remember that religious and spiritual practices may be healthy alternatives in resolving difficult crises or problems. Smith (1981) proposed that a therapist should look for a balance of religious maturity, psychic stability, and cultural integration to examine whether an African American exhibits a healthy or unhealthy religious orientation. A therapist can use traditional psychological assessments and incorporate additional religious and spiritual assessment questions before

Practicing Multiculturalism, 2004, Pearson Education

reaching a psychological diagnosis and before conceptualizing the case. Examples of religious and spiritual assessment questions will be provided in a subsequent section.

Social Groups and Significant Support Networks

Many African American families embrace the concept of reciprocity, incorporating a collectivist or group identity that encourages families to help and support each other and to share resources that help to ensure the survival of their communities (Boyd-Franklin, 1989). Social support for many African American families is found primarily in extended kinship networks, in the church and surrounding community, and through civic and other organizations including sororities and fraternities. African Americans form significant social support networks through participating in church-related activities and through membership in civic and political organizations including the NAACP, Urban League, National Council of Negro Women, Concerned Black Men, as well as cultural organizations that reflect their geographic origin including Caribbean and African organizations. Involvement in these organizations serves multiple purposes such as reinforcing shared values, attitudes, and beliefs; fostering pride in the group's cultural identity; providing a venue for effectively organizing members for a particular cause such as voter registration or fundraising; and mobilizing critical resources in times of crises.

Families and extended kin are the primary socializing agents for African American children, and many communities incorporate both formal and informal cultural activities such as rites of passage, mentoring, and cultural celebrations like Kwanzaa that help to connect individuals to their cultural heritage and values. In assessing the social support of African Americans, the therapist should be cognizant of the communal identity among African Americans which leads them to first seek help from members of their own communities, particularly within their extended family/kinship network. As noted earlier, the role flexibility that exists within extended kin networks tends to be mobilized during times of crisis (McGoldrick et al., 1996, p. 71). The "church family" has often been utilized as an important social service resource for many African Americans, both when they face crises such as homelessness and illness and when individuals are geographically isolated from their families (Boyd-Franklin, 1989). The relationship that is established with the African American client can, therefore, be the crux of therapy.

View of Mental Health

Several research studies have documented the disparity in the mental health utilization rates of various ethnic minorities (Sue & Sue, 1999). African Americans seldom use private therapists but may more often access community mental health centers. In 1976, the American Psychological Association Task Force on Health Research found that large numbers of disadvantaged and minority citizens lacked access to adequate health care. This was also true of mental health care. In addition, the Task Force found that racism affected service delivery in both direct and subtle ways. Sue (1977) analyzed detailed information on approximately 14,000 clients seen in 17 community mental health centers over a 3-year

Practicing Multiculturalism, 2004, Pearson Education

period. Sue found that African Americans and Native Americans were overrepresented in the community mental health centers and that African Americans were significantly more likely to terminate prematurely.

Sue, Fujino, Hu, Takeuchi, & Zane (1991) later investigated community mental health services to determine whether changes had occurred in mental health services that had adopted culturally responsive interventions in service delivery and outcomes for minority group clients, as compared to the 1977 study. The authors examined premature termination rates, number of sessions, and treatment outcomes and found that African Americans had a significantly higher dropout rate than other groups. Ethnic match between therapist and client proved to have a greater impact on the number of sessions attended than did treatment outcomes. While there appears to be progress in culturally responsive treatment, services for African Americans did not seem to improve, a finding which emphasizes the need to address ethnic match in therapy. The following is an experience of one of the authors at a counseling center that focused on this issue of ethnic match. This center was attempting to expand outreach to ethnic members on campus:

> At a counseling center in a private college located in a metropolitan city, African American students were asked whom they would consult if they experienced personal problems. Consistently, the students' verbal reports were that when experiencing problems they would first consult with a parent, family member, or extended family member. In some cases, the students indicated that they would also seek solace through their religion. When asked if they would seek help if the counseling center had an African American psychologist, many of the students indicated that they might if they were uncomfortable talking with someone in their personal network.

While these students' responses may be similar to those of students from other ethnic groups, the literature confirms that ethnic match may influence a client's willingness to request help and remain in treatment rather than affecting the actual therapy outcome. Often an ethnic match is helpful because the African American client perceives that an African American therapist shares a similar worldview or may be familiar with his or her culture (Helms & Cook, 1999). However, research also documents that clients cannot assume that similar ethnicity will guarantee culturally sensitive psychotherapy. Being an African American therapist does not guarantee sensitivity to or knowledge about African American cultures. There is also great diversity in African American culture (Cook & Wiley, 2000; Helms & Cook, 1999; McGoldrick et al., 1996), and it is quite possible that many African American therapists identify more with European American culture (since most training emphasizes theories based in European schools of thought) than African American culture. It is important, therefore, for therapists to be culturally competent regarding service delivery to African American clients because ethnic match is not always possible, due to the low percentage of African Americans in the mental health field (Dana, 1993; Sue & Sue, 1999), and, as stated previously, ethnic match does not guarantee culturally competent therapeutic interventions.

Practicing Multiculturalism, 2004, Pearson Education

Recommended Approaches to Counseling and Therapy

There are many texts that include useful information on approaches to therapy with African Americans (Dana, 1993; Helms & Cook, 1999; Lee, 1997; McFadden, 1993; Parham, White, & Ajumu, 2000; Ponterotto et al., 1995; Sue & Sue, 1999). In addition, Boyd-Franklin's (1989) work on *Black Families in Therapy* is a useful resource. Given the available information on treatment issues with African American or Black families, the authors will highlight those elements that have been found to be most effective with this population: racial identity, trust building, family therapy, group work, gender-sensitivity, and the assessment of spiritual and religious content in therapy.

Racial Identity Issues

The exploration of racial identity issues is crucial when working with African Americans. Internalized oppression and the coping methods for dealing with racism influence identity development (Helms & Cook, 1999). Jones (1985) has provided a model of racism as internalized trauma, comprising a four-pronged approach that explores the following factors: reactions to racial oppression, influence of the majority culture, influence of Afro-American culture, and personal experiences and endowments. It is also helpful to keep in mind that personal experiences may vary within groups. For example, African Americans who immigrate to the United States may struggle with the status of being considered "minority" and may not share the same experience or history of oppression as African Americans who were born in the United States. Yet both groups may have experienced oppression since, for example, it is not uncommon for class distinctions to occur within groups based on skin color, where those with lighter skin are more prized (Boyd-Franklin, 1989).

The United States has struggled for some time with race relations. It will be important for psychotherapists to understand the sociopolitical issues of slavery and oppression. The following exercise can foster this understanding:

> Imagine that you are taken to another country against your will and that you are separated from family and loved ones.
>
> Imagine that when you go to a new country, even though you were a doctor, lawyer, or business owner in your own place of origin, you are told you do not speak "standard English" or because of your "accent" you cannot communicate clearly enough to have access to certain jobs.
>
> Imagine that in this new country you cannot seem to transfer your talents and skills because there is a perception that your education or skills are not equivalent to those of persons in the new domicile.
>
> Imagine that when you interact with others, persons refer to you by the color of your skin.
>
> Imagine that you are treated by others not on the basis of your unique talents, intelligence, or self-worth but on the basis of the color of your skin.

Imagine that you notice that others, because they have a different skin color, have access to education, economics, certain neighborhoods, and certain jobs.

Imagine that when you turn on the television you see people of your skin color portrayed in destructive and negative ways and that television portrays your families as those without a father, but you know that there are many families in your culture with mothers and fathers.

What are some of your thoughts, feelings, and reactions to these "imagined" experiences? These *imagined* experiences are the reality for many African Americans.

Building Trust

Historically, African Americans have exhibited mistrust of formal mental health and medical institutions due to their experiences with prejudice, discrimination, or culturally insensitive treatment. Their reluctance to utilize formal mental health systems, along with their preference to seek help from family, extended kin, or religious or spiritual sources, may make building trust initially challenging. Therapists are encouraged to adopt a multisystemic approach with African American families, considering the impact of social, political, socioeconomic, cultural, and other broader environmental conditions on the client and the process of therapy (Boyd-Franklin, 1989).

Therapists need to explore their African American clients' fears about mental health interventions, to respectfully challenge their misperceptions about the treatment process, and to educate them about the process, including issues related to confidentiality and to client and counselor roles and responsibilities. Therapists should be open to questions about the process and be patient while actively working to gain trust by being genuine, empathic, and respectful when interacting with African American clients. Knowledge about African American culture and sensitivity to cultural differences and their possible impact on the therapy process are crucial. Therapists should also take the time to carefully examine and clarify clients' expectations and culturally influenced values. They must be willing to explore differences that may exist between themselves and their clients in these areas.

Self-disclosure by the therapist may also help reluctant African American clients who may initially feel uncomfortable talking about their "business" with a stranger. Therapists should be willing to disclose relevant information about themselves, as clients are more likely to open up if they feel they know something about the therapist as a person. Therapists should also be willing to be more directive in the beginning of therapy, as many clients will want concrete solutions and may view the therapist as an expert.

Family Therapy

In utilizing family therapy approaches, the therapist must seek to understand the client's definition of the family, its structure, and its function. As mentioned earlier, Hines and Boyd-Franklin (1996) have recommended that a genogram, a schematic diagram that visually depicts the structure of a family, can be a very effective method of obtaining information about family relationships and roles. Genograms typically include all significant

Practicing Multiculturalism, 2004, Pearson Education

family members, indicating their relationships to one another, ages, dates of marriage, births, deaths, and geographic locations (readers are encouraged to utilize McGoldrick and Gerson's (1985) text as a useful guide to constructing a genogram). It is crucial for therapists to recognize the diversity among families and to consider that the "typical" nuclear family is not the only kind of family that exists for African Americans. It is especially important to differentiate between *matrilineal* and *patrilineal* family relationships and to avoid confusing these terms with *patriarchal* and *matriarchal,* respectively. The former terms are kinship designations that do not imply rule by women or rule by men (Ingoldsby & Smith, 1995) but refer to the affiliation and inheritance that are passed on by the father and mother, respectively. Therapists who are willing to recognize diversity among families, and who are willing to challenge their assumptions, are in a position to be therapeutically effective with the African American client. Therapists must also be aware of their own definition of "family," as well as the definition and goal of their particular theoretical orientation.

Ingoldsby and Smith (1995) have provided an overview of the various definitions that family therapy approaches endorse, along with the contribution of these approaches to multicultural studies. For example, from a family system perspective the family is defined as "an organic system striving to maintain a balance as it confronts external pressures," whereas from a structural-functionalism viewpoint the family is "a structure that satisfies members' needs and operates for the survival and maintenance of society" (p. 30). Each theoretical framework offers its unique definition. Therefore, therapists may want to clarify their own definition of the family and ask themselves whether this definition is congruent with their theoretical framework. The following self-internalization questions may be useful to consider when working with African American clients:

What is my definition of family?

Does my definition of family fit with my theoretical orientation?

How can I integrate my definition of family and my theoretical framework with the client's definition of his or her family structure and function?

The role of extended kinship among African Americans must be a part of the clinical assessment. It is useful to consider that it is not uncommon for families to adopt blood relatives and non-blood relatives as part of their family without a legal process. Failure to consider these "adopted" members would be a disservice to clients. It is also not uncommon for family members to talk about the deceased as ongoing forces in the therapeutic process. The importance of spirituality and religion for the family and the roles of godparents are also underscored in the assessment process.

A particularly useful approach when working with Black families is the structural family therapy approach. The structural approach, which is primarily a problem solving approach, is well suited to therapy with Black families because it is clear, focused, specific, and directive (Boyd-Franklin, 1989). According to this approach, problems occur in families when the family structure, or the way in which the family is organized (including who is in charge of the family), is inflexible and/or poorly organized. Typically, family structures need to be well organized and flexible enough to adapt to changing circum-

stances. Families with poorly organized or inflexible structures fail to adjust adequately to changing circumstances, such as encountering stressful situations. The goal of structural family therapy is to alter and strengthen the family structure so the family can solve its own problems. Many African American families tend to have diverse structures, with extended and nontraditional family configurations. Therefore, it is important that therapists recognize all of the members considered as family by the African American client and work with all relevant family members. For a more detailed description and conceptual framework of this approach, see Aponte and Van Deusen (1981) and Minuchin, Lee, and Simon (1996).

Group Work

Group work can be extremely effective for African Americans. The traditional African view of nature is characterized by cooperative interdependence and group centeredness in human relationships (Lee, 1997). These allocentric tendencies can provide the context for change within a group setting since there is a tendency toward purpose (*nia*) and unity (*umoja*)—two of the seven principles of Kwanzaa. Matsumoto (1996) defines allocentrism as "the collectivistic tendencies on the individual level" (p. 32).

Research indicates that addressing issues of racial identity can be beneficial in a racially homogenous environment (Fukayama & Coleman, cited in Ponterotto et al., 1995; Shipp, 1983). Because most African Americans tend to present practical rather than personal problems (Ponterotto et al., 1995), groups that focus on issues and resolutions and that have clear boundaries and expectations can be most effective. Groups must also be structured in a way that fosters respect for individual differences and experiences.

Gender-Sensitive Practices

Many of the underlying principles of feminist theory, a form of gender-sensitive practice, are especially useful for the African American population. The increase of female elderly African Americans, the increased percentage of female-headed households, and the attention that has been given to African American males argue favorably for gender-sensitive theories. Ballou and Gabalac (1984) summarized the major tenets of feminist therapy, and two of these tenets, psycho-educational liberation and personal validation, will be highlighted as particularly useful in working with African Americans.

A strong psycho-educational component exists in feminist approaches to therapy. The therapist often is cast in the role of educator, not merely educating clients about therapy, but also providing instruction in social and historical facts concerning sexism, racism, and discrimination, as well as the impact of these facts on cultural conditioning and racial identity development. Issues of discrimination and prejudice can arise during therapy with the African American client. Therapy can be enhanced, therefore, by providing an external emphasis, where appropriate, to assist clients in placing their experiences in a social context. It is important to explore the sociopolitical context of clients' experiences. To simply dismiss the importance of the sociopolitical context will invalidate clients' stories. It is not enough that therapists focus primarily on helping clients to feel better about themselves.

Practicing Multiculturalism, 2004, Pearson Education

Therapists also need to consider key issues such as social context, oppression, racism, discrimination, and power as part of the assessment process and to become knowledgeable regarding the effects of these social constructs in influencing clients' worldviews and their perceptions. Ignoring context is one of the major downfalls of traditional therapies.

Another aspect of feminist therapy is an emphasis on personal validation, including respect for individual differences. In working with African Americans, the therapist must value differences and treat clients in a respectful manner. This is a core ethical principle for professionals in clinical practice (Principle D: Respect for People's Rights and Dignity) expressed in the Ethical Principles of Psychologists and Code of Conduct (APA, 1992). Valuing clients' rights includes valuing pluralism and taking into account the interface between gender and other forms of diversity such as religion and spirituality. For example, African American Islamic women, because of their faith and beliefs, may present with issues that are different than those of African American Christian women. The etiology, symptomatology, and participation in treatment may vary. Other diversity issues such as physical ability, gay or lesbian identity, and ageism are useful constructs for the psychotherapist to take into consideration when working with the African American client. Therapists who assume that the needs of all African Americans are the same, without recognizing the interplay of diversity and the uniqueness of the individual's cultural heritage as valuable to the therapeutic relationship, do a disservice to clients. This is especially important for African American clients whose values have been attacked over the years. Incidents such as the Moynihan (1965) report and the Tuskegee incidents have contributed to a lack of validation of the African community.

Spiritual and Religious Assessment and Intervention

Because many African Americans tend to use their spirituality and religion as sources of support, particularly during difficult times, therapists working with African American clients need to be comfortable incorporating these variables in therapy. Therefore, therapists must first assess their own beliefs and their level of comfort with religion and spirituality before conducting a religious or spiritual assessment. This personal assessment may reduce the effects of negative counter-transference or indicate areas where knowledge deficits related to religion and spirituality may need to be corrected. Such deficits may include understanding the difference between religion and spirituality; being aware of one's own religious and spiritual beliefs, including how they are similar to and different from those of the client; working to understand the client's religious and spiritual beliefs; recognizing the limits of one's tolerance of spiritual and religious phenomena; and, when necessary, being able to make appropriate referrals; having the ability to assess the relevance of religious and spiritual issues associated with the client's concerns; being able to utilize the client's spiritual and religious beliefs and expressions within sessions to meet the client's therapeutic goals and understanding how these beliefs affect treatment (Fukuyama & Sevig, 1999). The knowledge and comfort that a therapist exhibits regarding these issues will facilitate the development of a trusting relationship with many African American clients. Personal reflection on the following questions, typically directed to clients when conducting an assessment of their religious/spiritual beliefs, may provide an opportunity to develop or increase awareness of one's own spiritual/religious beliefs:

Practicing Multiculturalism, 2004, Pearson Education

> Describe your early experiences with religion or spirituality: What were the religious or spiritual backgrounds and experiences of your family members, and how did they introduce you to religion or spirituality? Were these experiences positive and/or negative? Were any particular religious practices or spiritual beliefs emphasized or de-emphasized in your family? In a crisis, did your family rely on God or a higher power, and if so, how?
>
> How have your beliefs changed over time, and what has influenced that change? Were there any particular life events that impacted you in a positive and/or negative way, which may have influenced your religious or spiritual development? Did any experience cause a religious or spiritual crisis in your life?
>
> What is the role of God or the higher power in your life right now? Would it be beneficial for you to use religion or spirituality during counseling or psychotherapy? If so, how?

Asking these or similar questions of clients can facilitate accurate understanding of their spiritual and religious contexts—and how these contexts may impact clients' current difficulties and coping. Once therapists are aware of these issues and clients have affirmed their desire to include spiritual or religious perspectives in therapy, relevant spiritual interventions can be incorporated. Common interventions include helping the client to clarify his or her spiritual values, using spiritual language or metaphors, acknowledging the client's prayer life, exploring religious concepts such as forgiveness, exploring spiritual elements in dreams, and using spiritual practices to cope with grief/loss. In doing so, therapists should remember that clients may have had negative experiences with religion or spirituality, and therapists should never impose their own beliefs on the client. Readers may benefit from obtaining Richards and Bergin's *A Spiritual Strategy for Counseling and Psychotherapy* (2003) and *Handbook of Psychotherapy and Religious Diversity* (2000) to gain additional information about religious and spiritual diversity issues.

Working from within an African American Worldview: Final Recommendations

Culturally sensitive attitudes, knowledge, and skills have already been identified. The following considerations are beneficial for therapists when integrating African American worldviews into the therapy process.

First, it is important that therapists adopt a strength-focused model when working with African Americans. Ford (1997) has pointed out that much of the literature on ethnic minorities has focused on those who are lower class, unemployed, or on welfare. This has been especially true of African Americans. While past research depicted African American families from a deficit or disadvantaged viewpoint (Frazier, 1966; Moynihan, 1965), more recent works have adopted a more balanced view of these families, including an emphasis on such strengths as family role flexibility, strong kinship bonds, education and work achievement, and religiosity (Billingsley, 1992; Boyd-Franklin, 1989; Hill, 1999).

Second, therapists must be willing to have clients share those experiences which involve the client's perception of reality, which often includes living in a world in which

Practicing Multiculturalism, 2004, Pearson Education

treatment is based on race (Helms & Cook, 1999). If the therapist is uncomfortable listening to and discussing these experiences, then it is likely that the client will not feel validated and will terminate therapy (Sue & Sue, 1999).

Third, therapists must recognize that although there may be universal characteristics that are found across ethnic groups, these characteristics may not be based on a similar worldview. For example, many European Americans, Asian Americans, Latino/as, African Americans, and West Indians value education and family, but each cultural group may approach the experiences with its own set of beliefs, expectations, roles, and rules.

Fourth, therapists must recognize that clients may experience varying levels of locus of control and locus of responsibility. Sue (1978) stated that mental health professionals further oppress minority clients when they approach problems expecting the client to adopt a worldview of internal control and internal responsibility. Sue noted that most psychology training programs emphasize internal control and internal responsibility, yet clients may approach life from a different locus.

Fifth, many therapists have been trained in individual therapy models and are not skillful in working with multisystems (Boyd-Franklin, 1989). Many clients may need practical assistance (e.g., citizenship concerns, housing); thus therapists must become familiar with integrating multiple systems into the treatment plan. Additionally, therapists can integrate spirituality and religious resources (e.g., prayer and meditation, reading spiritual and religious literature) into the therapy process. Finally, therapists most commit to developing and integrating multicultural competency as an ongoing professional goal.

Case Study of an African American Client

Allen was an 18-year-old African American male referred by his pediatrician for therapy. Allen intended to begin college, and his grandmother, Mrs. P., took him for a physical examination. The pediatrician called the therapist and stated that the grandmother was concerned about Allen because he appeared to be very stressed. The grandmother stated that she believed Allen's stress was related to the marital conflict between his stepmother and his father. The pediatrician referred Allen and his grandmother to this particular therapist because they had wanted someone who was sensitive to religious and spiritual issues. Upon receiving the referral and hearing the pediatrician's observations about Allen's high anxiety level and symptoms, the therapist concluded that it would be desirable to include a psychiatric evaluation by a consulting psychiatrist. The pediatrician responded, "Oh, no—he is a very bright young man and that is not necessary."

The grandmother accompanied Allen to the first session. She reported that Allen's father was retiring from the military and relocating his family from abroad. She also indicated that she and her husband had raised Allen and his brother Jeffrey from ages 5 and 7 until ages 9 and 11. She further indicated that the relationship of her son and the boys' mother had not lasted, and her son had felt it was in the boys' best interest for the grandparents to raise them while he was out of the country. The grandmother never explained why the mother could not raise the sons. The grandmother also reported that the father had retrieved his sons at ages 9 and 11 and had married a woman who had a

Practicing Multiculturalism, 2004, Pearson Education

daughter, age 5. He and his wife had then had two additional children. At age 17, Allen had decided that he wanted to have a relationship with his mother, so he had planned to attend a college near his mother's home. After only a few months of living with his mother, Allen realized the relationship was not as he had desired. He made the decision to leave quite suddenly, and he now sought to enroll in a college near his grandparents' home.

At the initial session, the therapist noted that Allen met most of the criteria for Generalized Anxiety Disorder. It was evident that he was experiencing a great deal of anxiety over his relationships with his parents and over numerous environmental transitions. The therapist obtained Allen's permission to contact his father and to solicit the father's input and involvement in treatment, even at a distance.

The next six sessions of therapy focused on building rapport, incorporating Allen's value for religion and for spiritual practices, exploring his emotions and thoughts related to the many conflicts and transitions in the family, and applying cognitive-behavioral strategies to help Allen learn relaxation skills. Therapy appeared to progress well until the seventh week when Allen skipped a session. He called and said that schoolwork was intense due to upcoming midterm examinations. Allen then missed the eighth week as well. The therapist was concerned because Allen was active in therapy. The next morning Allen's grandmother called and reported that Allen had had a nervous breakdown the day before and was in a local psychiatric clinic. When the therapist visited Allen in the clinic, his grandparents, father, and stepmother (who had flown home) were also present, and they reported that Allen had always demonstrated some unusual behaviors. The grandmother then reported that Allen had begun "cleansing his food in the oven" and talking "strangely during the past 3 weeks." The father reported that Allen's mother had seemed to have psychiatric problems and that she had been addicted to drugs. He wondered if Allen's behavior might be related to a genetic disorder. Allen was diagnosed with bipolar disorder with psychotic ideation, and he received medication and both individual and family treatment upon his release from the clinic. His symptoms notably decreased over time. He remained on medication, but he was able to discontinue therapy and succeed in his academic work.

This case provides examples of several issues that may arise in therapy with African American clients. The therapist validated the importance of the grandmother and of religious beliefs in Allen's life. The therapist was willing to have the client share experiences, such as family and religion, that were important in the client's worldview. The therapist also included the father and stepmother, even though doing so meant taking an additional step. Boyd-Franklin (1989) discussed the importance of including the extended family and working hard to include fathers, even if they are absent. The therapist recognized that while family is important to many ethnic groups, the definition and roles of family are not confined to the typical nuclear family. Upon first hearing Allen's symptoms, the therapist had wanted a psychiatric evaluation but trusted the evaluation of the pediatrician, who apparently had known the boy longer. The pediatrician's concern about a psychiatric evaluation

Practicing Multiculturalism, 2004, Pearson Education

(and she was an African American) was possibly related to mistrust of the establishment (Pierce & Pierce, 1984) and to concern that Allen would become part of the mental health system as an African American. The therapist later realized that the pediatrician was protective of Allen due to her concern of how this African American male may become part of a system that often treats people based on racial biases within the profession. The therapist realized that in the future she could trust her own intuition and clinical judgment, while at the same time acknowledging concerns related to the sociopolitical and cultural fears of African Americans. Knowledge of the sociopolitical context is important, but clinical acumen is paramount when dealing with all clients. The therapist also realized that many African American families might not initially report their observations (such as Allen's odd behavior) if they believe the child may be identified as abnormal. Research documents the history of pathologizing many African American clients (Helms & Cook, 1999), and Allen's family's realistic fear resulting from this unfortunate history almost prevented him from getting comprehensive mental health care. Multicultural competencies were demonstrated in this case by the awareness of the sociopolitical context, an understanding of the client's worldview, the ability to include various members of the mental health care team, and the continuation of treatment even after a major setback. The importance of therapists increasing multicultural awareness, knowledge, and skills is underscored.

References

Abreu, J. M., Goodyear, R. K., Campos, A., & Newcomb, M. D. (2000). Ethnic belonging and traditional masculinity ideology among African Americans, European Americans and Latinos. *Psychology of Men and Masculinity, 1*(2), 75–86.

American Counseling Association (ACA) (1995). *Code of ethics and standards of practice.*

American Psychological Association (APA) (1992). Ethical principles of psychologists and code of conduct. *American Psychologist, 47,* 1597–1611.

American Psychological Association (1993). Guidelines for providers of psychological services to ethnic, linguistic and culturally diverse populations. *American Psychologist, 48,* 45–48.

Aponte, H., & Van Deusen, J. (1981). Structural family therapy. In A. Gurman & D. Knickern (Eds.), *Handbook of Family Therapy* (pp. 310–360). New York: Brunner/Mazel.

Baldwin, J. A., & Hopkins, R. (1990). African American and European American cultural differences as assessed by the worldviews paradigm: An empirical analysis. *The Western Journal of Black Studies, 14,* 38–52.

Ballou, M., & Gabalac, N. (1984). *A feminist position on mental health.* Springfield, IL: Charles C Thomas.

Berry, J. W., & Annis, R. C. (1974). Acculturative stress: The role of ecology, culture and differentiation. *Journal of Cross-Cultural Psychology, 5,* 382–405.

Billingsley, A. (1992). *Climbing Jacob's ladder: The enduring legacy of African-American families.* New York: Simon & Schuster.

Boyd-Franklin, N. (1989). *Black families in therapy.* New York: Guilford Press.

Brislin, R. W., Lonner, W. J., & Thorndike, R. M. (1973). *Cross-cultural research methods.* New York: Wiley.

Cook, D. A., & Wiley, C. Y. (2000). Psychotherapy with members of African American churches and spiritual traditions. In P. S. Richards & A. E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 369–396). Washington, DC: American Psychological Association.

Cross, W. E. (1971). The Negro-to-Black conversion experience. *Black World, 20,* 13–27.

Cross, W. E., Parham, T. A., & Helms, J. A. (1998). Nigrescence revisited: Theory and research. In R. L. Jones (Ed.), *African American identity development.* Hampton, VA: Cobb and Henry Publishers.

Dana, R. H. (1993). *Multicultural assessment perspectives for professional psychology.* Boston: Allyn & Bacon.

Edmonson, B. (1993). What do you call a dark-skinned person? *American Demographics, 15*(10), 35.

Ford, R. (1997). *Counseling strategies for ethnic minority students.* Tacoma, WA: University of Pugent Sound. (ERIC Document Reproduction Service No. ED 247 504).

Franklin, A. J. (1996). The invisibility syndrome. *Family Therapy Networker,* pp. 33–39.

Frazier, E. F. (1966). *The Negro family in the United States.* Chicago: University of Chicago Press.

Fukuyama, M. A., & Sevig, T. (1999). *Integrating spirituality into multicultural counseling.* Thousand Oaks, CA: Sage.

Gary, L. (1985). Correlates of depressive symptoms among a selected population of Black males. *American Journal of Public Health, 75,* 1220–1222.

Grier, W. H., & Cobbs, P. M. (1968). *Black rage.* New York: Basic Books.

Gopaul-McNicol, S. (1993). *Working with West Indian families.* New York: Guilford Press.

Hays, P. (1996). ADDRESSING the complexities of culture and gender in counseling. *Journal of Counseling and Development, 74,* 332–338.

Helms, J. E., & Cook, D. A. (1999). *Using race and culture in counseling and psychotherapy: Theory and process.* Boston: Allyn & Bacon.

Hill, R. (1999). *The Strengths of African American Families: Twenty-five years later.* Lanham, MD: University Press of America.

Hines, P., & Boyd-Franklin, N. (1989). *Black families.* New York: Guilford.

Hines, P. M., & Boyd-Franklin, N. (1996). African American families. In M. McGoldrick, J. Giordano, & J. Pearce (Eds.), *Ethnicity and family therapy* (pp. 66–84). New York: Guilford Press.

Ingoldsby, B., & Smith, S. (Eds.) (1995). *Families in multicultural perspective.* New York: Guilford Press.

Jackson, A. P., & Meadows, F. B. (1991). Getting to the bottom to understand the top. *Journal of Counseling and Development, 70,* 72–76.

Jones, A. C. (1985). Psychological functioning in Black Americans: A conceptual guide for use in psychotherapy. *Psychotherapy,* 22, 363–369.

Lee, C. (1997). *Multicultural issues in counseling* (2nd ed.). Alexandria, VA: American Counseling Association.

Lee, C., & Bailey, D. F. (1997). Counseling African American male youth and men. In C. Lee (Ed.), *Multicultural issues in counseling* (2nd ed.) (pp. 123–154). Alexandria, VA: American Counseling Association.

Matsumoto, D. (1996). *Culture and psychology.* Pacific Grove, CA: Brooks Cole.

Mbiti, J. S. (1991). *Introduction to African religion* (2nd ed.). Oxford, England: Heinemann Educational Publishers.

McFadden, J. (1993). *Transcultural counseling: Bilateral and international perspective.* Alexandria, VA: American Counseling Association.

McGoldrick, M., & Gerson, R. (1985). *Genograms in family assessment.* New York: W. Norton and Company.

McGoldrick, M., Giordano, J., & Pearce, J. K. (Eds.) (1996). *Ethnicity and family therapy* (2nd ed.). New York: The Guilford Press.

McKinnon, J., & Humes, K. (2000). The black population in the United States: March, 1999. U.S. Census Bureau. Current Populations Report, Series P20-730. Washington, DC: U.S. Government Printing Office.

Minuchin, S., Lee, W. Y., & Simon, G. M. (1996). *Mastering family therapy: Journeys of growth and transformation.* New York: Wiley.

Moynihan, D. P. (1965). *The Negro family: The case for national action.* Washington, DC: U.S. Department of Labor.

National Association of Social Workers. (1993). *Code of ethics.* Washington, DC: Author.

Nobles, W. W. (1991). African philosophy: Foundations for black psychology. In R. L. Jones (Ed.), *Black Psychology* (pp. 47–63). Berkeley, CA: Cobb & Henry.

Nwadiora, E. (1995). Alienation and stress among Black immigrants: An exploratory study. *Western Journal of Black Studies, 19,* 59–71.

Parham, T. A., White, J., & Ajumu, A. (2000). *The psychology of Blacks: An African centered perspective.* Upper Saddle River, NJ: Prentice Hall.

Pierce, L. H., & Pierce, R. L. (1984). Race as a factor in the sexual abuse of children. *Social Work Research and Abstracts,* 9–14.

Ponterotto, J. G., Casas. J., Suzuki, L. A., & Alexander, C. M. (1995). *Handbook of multicultural counseling.* Thousand Oaks, CA: Sage.

Richards, P. S., & Bergin, A. E. (Eds.) (2003). *A spiritual strategy for counseling and psychotherapy.* Washington, DC: American Psychological Association.

Richards, P. S., & Bergin, A. E. (Eds.) (2000). *Handbook of psychotherapy and religious diversity.* Washington, DC: American Psychological Association.

Shipp, P. L. (1983). Counseling Blacks: A group approach. *Personnel and Guidance Journal, 62,* 108–111.

Smith, A. (1981). Religion and mental health among blacks. *Journal of Religion and Health, 20,* 264–287.

Sue, D. W. (1977). Barriers to effective cross-cultural counseling. *Journal of Counseling Psychology, 24,* 420–429.

Sue, D. W. (1978). Eliminating cultural oppression in counseling: Toward a general theory. *Journal of Counseling Psychology,* 25, 419–428.

Sue, D. S., Fujino, D. C., Hu, L., Takeuchi, D. T., & Zane, N. W. S. (1991). Community mental health services for ethnic minority groups: A test of the cultural responsiveness hypothesis. *Journal of Consulting and Clinical Psychology, 59,* 533–540.

Sue, D. W., & Sue, D. S. (1999). *Counseling the culturally different: Theory and practice* (3rd ed.). New York: John Wiley and Sons, Inc.

Practicing Multiculturalism, 2004, Pearson Education

United States Census Bureau. (1990). We, the American Blacks. Report issued on September, 1993. U.S. Government Printing Office.

United States Census Bureau. (February 22, 2001). *Census bureau facts for features.* Retrieved October 19, 2001 from http://www.census.gov/Press-Release/www/2000/cb00-158.html

Washington, C. S. (1987). Counseling Black men. In M. Scher, M. Stevens, G. Good, & G. A. Eichenfield. (Eds.), *Handbook of counseling and psychotherapy with men* (pp. 192–202). Newbury Park, CA: Sage.

Watkins-Duncan, B. (1992). Principles for formulating treatment with Black patients. *Psychotherapy, 29,* 452–456.

White, J. (1972). Toward a Black psychology. In R. Jones (Ed.), *Black psychology* (pp. 43–50). New York: Harper & Row.

White, J. L., & Parham, T. A. (1990). *The psychology of Blacks: An African American perspective.* New York: Prentice Hall.

Winkleman, M. (1994). Cultural shock and adaptation. *Journal of Counseling and Development, 73,* 121–126.