Guidelines for the Assessment and Treatment of African American Clients

In the 2000 U.S. Census, approximately 34.6 million individuals (12.3% of the total U.S. population) self-identified as “Black or African American.” In addition, 1.8 million defined their race as Black or African American in combination with one or more other races (Grieco & Cassidy, 2001; U.S. Bureau of the Census, 2000). In this mixed-race group, the races most commonly reported in combination with Black or African American were as follows: White (784,764 individuals reported African American–White biracial status), American Indian and Alaska Native (182,494 individuals), White and American Indian and Alaska Native (112,207 reported this multiracial status), and Asian (106,782 individuals) (Grieco & Cassidy, 2001). In the same census, approximately 5.5 million persons reported that they were White in combination with one or more other races; the second-most-common combination in this group was White and African American (as noted above, 738,764 individuals reported their race as White and Black or African American; 868,395 described themselves as White and Asian).

These findings suggest that although only approximately 12% of the total U.S. population self-identify as Black or African American only, clinicians should be aware of the possibility that they may serve clients who consider themselves both African Americans and members of other races (e.g., American Indian, Asian). As noted in Chapter 2, clinicians who serve biracial and multiracial clients must use culturally sensitive strategies in the assessment, diagnosis, and treatment of those clients.

Socioeconomic Status

At the time of the 2000 U.S. Census, the median income of African American families was $29,470, far below both the national U.S. median of
$42,228. The median among White families at that time was $44,517 (U.S. Bureau of the Census, 2002a). The average income per household member among African American families was $15,007, compared with $12,158 for Hispanics, $22,688 for Asians and Pacific Islanders, and $24,951 for Whites (U.S. Bureau of the Census, 2001, 2002b). Approximately 8.2 million, or 24.9%, of those who self-identified in the census as Black or African American (not in combination with other races) were living below the poverty level, in comparison with 12.4% of the U.S. population as a whole and 9.1% of respondents who self-identified as White (not in combination with other races) (Bishaw & Iceland, 2003).

Cultural Variables That May Affect Assessment and Treatment

Racial Labels

Racial labels have been a concern to African Americans for many years (Smith, 1992). Members of this group have been referred to as Colored, Negro, Black, and African American. The first three of these terms emphasize skin color, whereas the last emphasizes cultural heritage; African American is the term currently recommended most often in the literature (Griffith & Baker, 1993; Smith, 1992). Mental health professionals should not use the terms Colored and Negro, as these are considered derogatory (Smith, 1992). The terms Black and African American both seem to be acceptable within particular contexts. For example, in an article published in the Houston Chronicle, an interviewee who was asked about both terms responded that “if a brother or sister wants to call me black, that’s OK. But I would prefer that Anglos call me African American.... It acknowledges our ancestry and were we came from, and I think that use of that term by Anglos is more respectful” (quoted in Karkabi, 1993, p. 5D).

It is appropriate for therapists to explore with their African American clients which term (Black or African American) the clients prefer. A practical strategy is for the clinician to ask the client directly about this matter. Whether the client states a preference for Black or African American, the therapist should honor the client’s wishes and stay neutral with respect to any controversy that may exist regarding the use of either term (for an excellent summary of such controversy, see Smith, 1992).

In addition, clinicians should be aware that in the 2000 U.S. Census respondents were allowed for the first time to identify themselves as members of more than one race (see Chapter 2 for discussion of this topic). This suggests that a clinician is likely to find it very difficult to determine and label a client’s racial status in the absence of the client’s own self-designation. For example, a given client may not consider him- or herself
to be “Black” or “African American” only, but “African American and White” (i.e., biracial) or “African American and White and American Indian” (multiracial). Again, the best approach for the clinician to follow is to ask the client how he or she would like to be designated in terms of race (particularly if the information requested is needed to track clinical findings across different races or for research purposes).

As noted in Chapter 2 (see Box 2.1), the U.S. Bureau of the Census included the term *Black* (in the designation “Black or African American”) in the racial categories used in the 2000 census (categories created by the Office of Management and Budget). Even given that usage, in this new edition I am emphasizing the use of the term *African American*, as I did in earlier editions (see Paniagua, 1994, 1998), because it continues to be the term with the most acceptability in the literature (see, e.g., Dana, 1993b; Gibbs, Huang, & Associates, 2003; Griffith & Baker, 1993; Ho, 1992; Smith, 1992; Sue & Sue, 2003). Among the reasons scholars have given for their preference for the term *African American* are that it is less stigmatizing than *Black* (Dana, 1993b), that it emphasizes cultural heritage rather than skin color (Griffith & Baker, 1993), and that it formalizes the connection between African Americans and the continent of Africa (Fairchild, 1985).

**Familism and Role Flexibility**

In general, among African Americans both the nuclear family (parents and children) and the extended family (grandparents, aunts, uncles, and other relatives as well as friends, clergy, and others who provide instrumental and social supports) are important (Boyd-Franklin, 1989; Smith, 1981). Because the concept of *familism* among African Americans generally includes both biologically and nonbiologically related persons, an important guideline for the clinician to follow with a client from this group is to formulate a genogram that emphasizes the client’s extended family tree (as defined in Chapter 2) rather than simply the biological family tree. (This guideline holds also for American Indian, Asian, and Hispanic clients.)

Among African American clients, the head of the family is not necessarily the father (Baker, 1988). An important feature of African American families is *role flexibility*: That is, sometimes the mother plays the role of the father as well as the mother, and thus functions as the head of the family, and older children sometimes function as parents, caring for younger children. In fact, it is not uncommon for older African American children to drop out of school so that they can go to work and help their younger siblings secure a good education (Baker, 1988; Ho, 1992; Smith, 1981). Therapists should carefully consider this practice when conducting family therapy with African American families that include adolescents; therapists should not assume that school dropout among adolescents in these families is the result of the problems the parents have brought to the therapists’
attention. In addition, as Boyd-Franklin (1989) notes, the concept of role flexibility among African American families can be extended to include the parental role sometimes assumed by grandfathers, grandmothers, aunts, and cousins. Therefore, in assessing an African American client, the therapist should attempt to determine which family member was functioning as the head of the family at the moment of the referral.

Religious Beliefs

For many African Americans, the church (particularly an African American church) is an important part of the extended family (Griffith, English, & Mayfield, 1980; Levin & Taylor, 1993). Therefore, it is important that therapists explore the role that the church plays in the life of each African American client. An initial step is to ask the client whether he or she has a particular church affiliation and, if so, what that is. The majority of church-affiliated African Americans are members of Baptist or African Methodist Episcopal churches (Boyd-Franklin, 1989), but many others worship as Jehovah’s Witnesses, Seventh-Day Adventists, Pentecostals, Presbyterians, Lutherans, Episcopalians, and Roman Catholics or as members of the Church of God in Christ or the Nation of Islam.

Despite the central role that the church plays in the life of many African Americans (Smith, 1981), it is important that mental health practitioners avoid assuming that all of the African American clients they serve have strong church ties. To explore whether a particular client includes the church in his or her extended family, the therapist might ask, “Have you discussed your emotional problems with anyone in your church?” Note that “anyone” here could refer to a fellow church member, a minister, a priest, or anybody else with some connection to the client’s church. If the client indicates that members of his or her church are essential in providing the client with instrumental and emotional support, the therapist could ask, “Would you like to include these church members in our discussion of your concerns?”

Folk Beliefs

Some African Americans believe that folk medicine can be effective in the treatment of both medical and mental problems (Baker & Lightfoot, 1993; Wilkinson & Spurlock, 1986). The belief systems of many African Americans include the idea that mental problems can have either physical causes or causes that may be described as occult or spiritual. If an illness has a physical cause, according to such beliefs, it can be cured with herbs, teas, and other natural substances; in such a case, an individual might consult a folk doctor for treatment. If an illness is perceived to have been caused by occult or spiritual factors (including evil spirits, supernatural
forces, violation of sacred beliefs, and sin), the individual might consult a
folk healer (Dana, 1993b).

Some African Americans might seek help for mental health problems
from one of several types of healers. The kind of healer known as the old
lady generally deals with common ailments; she provides advice and gives
medications (e.g., herbs). The old lady is most often consulted by young
mothers. The spiritualist is the most common kind of folk healer consulted
by African Americans seeking help in dealing with their problems. The
voodoo priest, or hougan, has more formal training in the process of heal-
ing than do other folk healers (including training in how to select plants to
be used for healing purposes and which organs or other parts of certain
animals clients should ingest to treat particular problems, as well as train-
ing in the skills needed to help clients deal with individual and family prob-
lems). In addition to seeking the help of folk healers, many African
Americans believe that the solutions to their problems should include
involvement with Bible study groups, prayer meetings, and advice from
clergy (Dana, 1993a). To enhance their ability to assess and treat African
American clients appropriately, therapists need to understand these clients’
beliefs regarding the causes of mental health problems and their solutions
(Baker & Lightfoot, 1993; Smith, 1981).

Healthy Cultural Paranoia

Slavery and racism are two important factors in the history of African
Americans in the United States that have dramatically shaped the social
and psychological development of the members of this group over time
(Gregory, 1996; Smith, 1981). An important consequence of these factors
has been the development of healthy cultural paranoia among African
Americans (Ho, 1992; Smith, 1981). Many African Americans present
themselves as highly suspicious of people of other races and of those who
hold values that are different from theirs; such an attitude can interfere with
the client-therapist relationship. However, when a therapist perceives that
an African American client does not trust him or her, the therapist should
avoid asking the client to explain that distrust; asking for an explanation
demonstrates a lack of understanding of the phenomenon of healthy cul-
tural paranoia, and the client may then perceive the therapist as culturally
insensitive.

The Language of African American Clients

Communicative exchange between client and therapist is an essential
element in the process of psychotherapy; this applies to all forms of ther-
apy, not only to what has been termed “talk therapy.” Effective commu-
unicative exchange may be difficult to achieve when the client uses words,
syntax, and phonology with which the therapist is unfamiliar (Wilkinson & Spurlock, 1986). This point is particularly important for practitioners to remember in the assessment and treatment of African American clients, who may use Black English rather than Standard English or street talk during the therapeutic process.

Both Dillard (1973) and Smitherman (1995) provide a wide variety of examples to demonstrate the distinctions between Standard English and Black English. For instance, the two forms of English differ in terms of grammar; the question “Have they gone there?” in Standard English might be phrased “Is they gone there?” in Black English (Dillard, 1973, p. 49). Because of differences between Black English and Standard English, a therapist may misunderstand what an African American client is saying. For example, in Black English the sentences “My child sick” and “My child be sick” mean two different things: The first sentence indicates that the child is currently sick and the sickness is of short-term duration, whereas the second sentence indicates that the child has been sick for a long time (Dillard, 1973). As Smitherman (1995) explains, in Black English the verb be is used to “indicate continuous action or infrequently occurring activity” (p. 7).

African American clients’ use of street talk may also affect the assessment and treatment of members of this group. In using street talk, a client may or may not use Standard English; in either case, the therapist may have problems understanding what the client is saying because the client is using words or phrases with which the therapist is unfamiliar. For example, the sentence “I would like to have plenty of bank to buy a hog to go to Cali” is grammatically correct in Standard English, but the listener cannot understand this sentence unless he or she knows the meanings of the slang words bank (money), hog (Cadillac or, more generally, any car), and Cali (California) (see Dillard, 1973, p. 240; Smitherman, 1995, pp. 54, 75, 135). Additional examples of Black street talk are “I was mad at her because she was not clean” (clean in this specific case means dressed up or stylishly dressed); “If I get a gig, I will feel better” (gig means job); and “He likes to rap with the dude who lives across the street” (rap means talk, dude means man).

The basic guideline for the practitioner concerning language is this: If the therapist cannot understand the language of an African American client, the therapist should ask the client directly to clarify what he or she means. Several African Americans with whom I consulted as I was writing this chapter told me that, in many instances, they have problems understanding individuals who use Black English and street talk. Thus a therapist of any race who cannot understand the language used by an African American client should not feel embarrassed to ask questions that will enhance client-therapist communication. The therapist should be careful, however, not to give the impression that he or she is questioning the correctness of the client’s use of Black English rather than Standard English or the correctness of particular words. The therapist must reassure the client, both verbally
and nonverbally, that he or she is asking for clarification only to facilitate the verbal exchange between therapist and client, which is crucial to the therapist’s understanding of the client’s concerns.

The First Session

The therapist’s first session with any client sets the tone for a healthy client-therapist relationship in subsequent sessions (Baker, 1988; Ho, 1992; Smith, 1981). The literature suggests specific guidelines concerning the cultural skills a therapist should employ during the first encounter with an African American client.

Discussing Racial Differences

Because of the history of racism and discrimination against African Americans by the dominant Anglo-American culture, an African American client referred to an Anglo-American therapist is likely to come to the first session with the belief that the therapist is an “alien” who will not be able to understand the client’s problem because of racial differences. To minimize these feelings, the therapist should begin the first session by acknowledging the racial difference between therapist and client and encouraging the client to talk about his or her feelings concerning this issue. (An exception to this guideline is that if the session is part of a brief or emergency intervention involving a crisis, the therapist should not raise issues of race; Wilkinson & Spurlock, 1986.)

When the therapist is White and the client is African American, the therapist might begin talking about race during the first session by saying, “Some African American clients feel uncomfortable when they are referred to a White therapist. Perhaps we could briefly talk about any feelings you may have regarding our racial differences.” Boyd-Franklin (1989) suggests that the therapist simply ask, “How do you feel about working with a white therapist?” (p. 102). Such general comments and questions may not only reduce racial tension between the client and the therapist, they may also help the therapist to looks less anxious, more comfortable, and more sensitive to the client’s expectations and beliefs (Baker, 1988). In addition, when the therapist discusses racial issues openly with an African American client, the client may feel reassured that he or she is in a safe environment where anything can be discussed.

Another important guideline for the therapist is to avoid further discussion of racial issues in subsequent sessions (unless the client brings them up). By continuing to raise such issues after the first session, a White therapist may convey to an African American client the impression that the therapist is anxious about the potential effects of cross-racial issues and that
this anxiety may interfere with his or her ability to assess and treat the client effectively (Boyd-Franklin, 1989).

It should be noted that discussion of racial issues in the first session may also be important when the client and the therapist are both African Americans. Although often African American practitioners assume that it is unnecessary to discuss race with their African American clients because those clients are likely to be less suspicious and guarded, more relaxed, and more open to discussing personal problems with them than they would be with therapists of other races, they may be mistaken in this assumption (Boyd-Franklin, 1989; Wilkinson & Spurlock, 1986). For example, as Boyd-Franklin (1989) points out, because many male African Americans hold beliefs that may be described as “macho,” a client from this group may find it difficult to discuss personal matters openly with an African American therapist. In addition, an African American client being treated by a therapist from the same race may “check out” the therapist for nonverbal cues that suggest the therapist is distancing him- or herself from the client; this may result in the client’s displaying the same kind of healthy cultural paranoia generally assumed to be part of African American clients’ relationships with White therapists.

One important guideline for an African American therapist treating a client from the same race is to avoid thinking that racial similarity will necessarily enhance (or guarantee the success of) the therapist-client relationship. An African American therapist working with an African American client should take care to present both verbal and nonverbal behaviors aimed at establishing the therapist as a peer of the client; the therapist should not assume that the client will consider the therapist a peer simply because he or she is African American. An African American therapist might indicate his or her interest in discussing racial issues with a client of the same race by saying something like the following: “African American [or Black, depending on the client’s stated preference] clients sometimes feel uncomfortable discussing mental problems with African American mental health professionals. Because I am an African American, I am wondering if you might have any such feelings.” To facilitate a verbal exchange with the client on this particular issue, the therapist should avoid sitting behind a desk; by making sure there are no barriers between therapist and client, the therapist signals that he or she does not want to distance him- or herself from the client and conveys the sense that he or she will take the discussion of racial issues very seriously. This physical arrangement is recommended throughout the entire process of therapy as well, to continue the development of trust between client and therapist (Boyd-Franklin, 1989).

It is important to make a distinction between a discussion of racial issues to facilitate assessment and treatment during the first session and the African American therapist’s (explicit or implicit) role as a “protector of the race” (Boyd-Franklin, 1989). African Americans are aware of the history of
slavery, racism, and rejection experienced by members of their race in the United States. Thus an African American client may become suspicious of an African American therapist who, in the process of assessment and treatment, presents him- or herself as a member of this race who has the education and training to “preach and teach” African American clients. Therefore, in addition to scheduling a brief period to discuss racial issues in the first session with an African American client, the African American therapist should avoid mixing any discussion of racial issues intended to help develop the therapist-client relationship with discussions of political and racial problems in society.

Regardless of the race of the therapist, a discussion of racial differences during the first therapy session with an African American client does not necessarily guarantee the enhancement of the therapist-client relationship in subsequent sessions. As Wilkinson and Spurlock (1986) note, “The therapist’s openness, sensitivity, and ability..., training and experience, are generally more important” in this regard (p. 51).

**Exploring the Client’s Level of Acculturation**

The fact that a client is African American does not necessarily mean that the client identifies as African American (Dana, 1993b; Ho, 1992). Some African American clients identify more strongly with the Anglo-American culture than with African American culture and may display behavior patterns much like those found in the Anglo-American community (e.g., styles of dress, music, language). An African American may acquire such behavior patterns and preferences through the internal acculturation process described in Chapter 2. In the first session with an African American client, the therapist should determine how the client perceives his or her identity: Does the client identify more strongly with the dominant culture or with the culture of his or her own race (Sue & Sue, 2003)? One way in which the therapist might explore this issue is by encouraging the client to talk about his or her past and current experiences with the African American community versus his or her experiences with the Anglo-American community. In addition, the Brief Acculturation Scale may be useful (see Figure 2.1 in Chapter 2).

**Avoiding Offering Causal Explanations for Problems**

Many African American clients believe that emotional problems are caused by environmental factors. Thus the therapist should avoid linking an African American client’s mental health problems with, for example, the behavior of the client’s parents or other members of the client’s extended family. The therapist should not offer any possible explanations regarding
the origin of the problems during the first session. During this session, an African American client is likely to prefer that the therapist provide concrete suggestions regarding how to solve the mental problems rather than a long and complex explanation of the problems’ origin (Baker, 1988).

Including the Church in the Assessment and Therapy Processes

As noted above, the church plays a major role in the lives of many African Americans (Dana, 2002; Griffith et al., 1980; Sue & Sue, 2003; Taylor & Chatters, 1986). It is particularly important that therapists remember this fact when assessing and treating African American women, because they tend to be more involved with church activities than are African American men (Levin & Taylor, 1993). A practical guideline for the therapist is to determine whether the client is a member of a particular church and, if so, how the client perceives the church as a source of economic and emotional supports. If the client indicates an affiliation with a church, the therapist should inform the client that he or she is welcome to bring fellow church members to subsequent sessions to help with the assessment and treatment of the client’s concerns. For example, the therapist might say, “If you believe that someone in your church should be invited to discuss this problem with you and me, please let me know, and I will be glad to extend an invitation to that person to join us at our next session.”

If the therapist is aware prior to the first session (e.g., because the client has mentioned it when scheduling the session) that the client belongs to one of the churches in the community, the therapist should let the client know in advance, either on the phone or in writing, that he or she is welcome to bring any church member he or she wishes to the first meeting. Therapists should make sure that their support staff members (e.g., secretaries, mental health paraprofessionals) are aware of this guideline as well, because in many instances the therapist is not the person who makes the first contact with a client.

With an African American client who is a new resident in the community, it is important for the therapist to find out whether the client has already found a church that fulfills his or her religious needs. Of course, the therapist should be familiar with the churches available in that particular community. A good approach is for the therapist to have available for African American clients a list of the names, telephone numbers, and addresses of all of the churches in the community. As Boyd-Franklin (1989) notes, by helping an African American client find a church, a therapist may contribute significantly to the process of psychotherapy (e.g., the client’s minister may encourage the client to continue going to therapy sessions or to follow the therapist’s recommendations). In addition, this sort of assistance may greatly enhance the therapist-client relationship.
Defining the Roles of Those Accompanying the Client

Many African American clients assume that they may bring members of their extended families to an initial session with a therapist (Baker, 1988). The people they bring with them often include both relatives (e.g., uncle, aunts) and nonrelatives (e.g., friends, godparents, fellow church members). To avoid making false assumptions about the roles of those who accompany a client to the first session, the therapist must clarify the role of each person prior to beginning to assess the case. The therapist’s main concern should be to determine whether any of these individuals may be helpful in the evaluation and treatment of the client (Griffith & Baker, 1993). In addition, the therapist should be aware of the importance of the presence of the client’s grandmother at the first meeting. Given that the grandmother is probably the second-most-important member of the client’s extended family (Boyd-Franklin, 1989), the grandmother’s attendance at the first session is often a sign that she offers the client a great deal of social and/or spiritual support.

In many African American families the primary caretaker of children is not the mother but the grandmother. A grandmother may bring a child to a clinic for assessment and treatment, but she may lack an understanding of the fundamental psychological and developmental processes that are relevant to the assessment and treatment of the child. The therapist must be aware that, despite her lack of understanding, the grandmother is likely to be responsible for making major decisions regarding the child’s life. For example, the child’s mother may not follow the therapist’s recommendations for treatment of the child without the approval of the child’s grandmother. For this reason, an important guideline for the therapist who is working with an African American child is to explore quickly in the first session the role of the grandmother in the child’s life. If the therapist perceives that the grandmother’s role is crucial, he or she should invite the grandmother to attend subsequent therapy sessions and to participate actively in the child’s assessment and treatment.

Using an Approach With a Present-Time Focus

During the first session, an African American client might bring up both the core, or most essential, problem that he or she feels should be considered first and additional problems that may be handled in later sessions (Baker, 1988). The therapist should be aware that the client probably expects to receive suggestions for a focused, brief intervention to deal with the core problem quickly.

Screening for Depression and Schizophrenia

Griffith and Baker (1993) suggest African Americans may be under-diagnosed for depression because of a common myth that African Americans
rarely become depressed. These authors recommend that a therapist screen an African American client concerning the following before concluding that the client does not have major depression:

1. Neurovegetative signs (e.g., weight loss, fatigue)
2. View of the future
3. Past and current sources of pleasure from specific persons
4. Level of productivity
5. Degree of participation in church activities
6. Degree of participation as a caregiver for younger family members

The diagnosis of schizophrenia appears to be more common among African American clients than among White clients (Good, James, Good, & Becker, 2003). Clinicians should be aware of the potential explanations for this finding so that they can avoid misdiagnosing their African American clients. Among the reasons African Americans may be overdiagnosed as schizophrenic are the phenomenon of healthy cultural paranoia, as described above; the belief in spirit possession held by some African American clients; and perceptions of these clients associated with racial stereotyping, such as that they are “dangerous,” “aloof,” and “argumentative” (e.g., see the definition of paranoid-type schizophrenia in the *DSM-IV-TR*; American Psychiatric Association, 2000, pp. 313–314). (Chapter 9 includes a detailed summary of this topic; see also Good et al., 2003.)

Griffith and Baker (1993) have suggested that the high prevalence of schizophrenia reported among African American clients might be related to substance abuse. Hallucinations and delusions, which are the key symptoms in a diagnosis of schizophrenia, can also result from chronic alcoholism and the use of illicit drugs (e.g., powdered or crack cocaine, heroin). Thus during the first session with an African American client the therapist should screen for a history of substance abuse. If a client arrives at a clinic with symptoms of schizophrenia that abate within approximately 2 hours in the absence of treatment (e.g., medication), the client probably has experienced cocaine psychosis. If the therapist fails to screen for substance abuse in such a case, the result might be an erroneous diagnosis of schizophrenia.

**Handling Family Secrets With Care**

During the first session with an African American client, the therapist should take care to be sensitive to the possibility of family secrets. The key point for the therapist to remember in this respect is to wait for the natural revelation of any family secrets over time, because in most cases they will eventually be revealed (Boyd-Franklin, 1989). Family secrets can take
many forms, including reasons for adoption (e.g., why a child was adopted by an aunt), use of drugs by parents (and other members of the family), past problems with the police that have led to arrests and convictions, and secrets regarding fatherhood (Boyd-Franklin, 1989).

The literature offers therapists specific guidelines regarding methods for identifying the secrets that might exist in the family as well as general guidelines concerning appropriate ways to handle these secrets during the first session. For example, if a grandmother brings her grandchild to the child’s first therapy session and states that she has adopted the child without providing a reason for the adoption, the therapist should suspect that the grandmother is protecting a family secret. If an adolescent client asks his parents in the presence of the therapist, “Why do I look different from my brothers?” and the parents avoid answering the question, this could also be a case involving a family secret. The therapist might suspect a family secret if he or she says to a client, “Could you tell me about your life when you were an adolescent?” and the client replies, “I don’t feel talking about that now.”

The basic first-session guideline for the therapist regarding suspected family secrets includes three elements: The therapist should listen carefully to what the client says, attend to the amount of silence that follows when the client is questioned about an issue that appears to be sensitive, and avoid asking questions that may imply that there are family secrets or that may lead to their revelation. For example, during the first session with a child client, the practitioner generally expects one or both parents to be present to register the child and sign documents dealing with consent for assessment and treatment. If a parent (either the mother or the father) is not present to fulfill these tasks, the therapist should not ask whoever has accompanied the child (whether a grandparent, an adult brother or sister, an adult aunt or uncle, or someone else), “Why is the child’s mother not here today?” Although at first glance this question may seem appropriate, the therapist needs to understand that by asking it he or she is inviting the premature discussion of a family secret, and the result could be attrition (i.e., the family may not come back for additional sessions).

In circumstances such as those in this example, the therapist should take the following steps. First, he or she should inquire about the relationship between the child and the person seeking help for the child (e.g., a grandparent) to help determine who has legal guardian status in regard to the child. Second, the therapist should clearly state that if the child’s legal guardian is not present, the therapist will see the child only to determine whether the child’s needs require immediate attention (e.g., suicide attempts). If the person who has brought the child in for treatment states that he or she is not the legal guardian, the therapist should say something like the following: “I am very pleased that you brought Sue to the clinic today; this shows that you care about her. I will see Sue now only to determine that she is not a danger to herself or to others. The next time you bring
Sue to the clinic, it would be helpful if you would also bring her legal guardian to sign consent forms that will allow me to conduct further assessment and therapy.” Such a statement not only avoids questions dealing with family secrets, it also provides the individual with an opportunity to mention the child’s legal guardian without pressure from the therapist. In addition to taking these two steps, the therapist must be familiar with all laws and regulations in his or her state regarding consent for the assessment and treatment of children and adolescents. For example, in Texas any adult family member (e.g., a grandparent, an adult brother or sister) may give consent for the treatment of a child “when the person having the power to consent . . . cannot be contacted and actual notice to the contrary has not been given by that person” (Costello & Hays, 1988, p. 87).

Avoiding “Trying Too Hard”

A few years ago, the presenters of a workshop on the assessment and treatment of African American clients offered by the Texas Psychological Association made the following observation: If a therapist tries too hard to understand African Americans, he or she probably does not understand them at all. Boyd-Franklin (1989) makes a similar observation. She gives as an example an Anglo therapist who uses what the therapist thinks are current African American slang terms when talking with African American clients in an “attempt to join with the [African American] family” (p. 100). Therapists should avoid this approach for two reasons: First, they may use the slang inappropriately, which will lead their African American clients to see them as less culturally competent; and second, some African American clients may see such actions as condescending.

Emphasizing Strengths Rather Than Deficits

During the first session with an African American client, it is important that the therapist avoid any suggestion (either verbal or nonverbal) that the client likely comes from a disorganized, unstable, and psychologically unhealthy family. This characterization of African American families, which was prevalent during the 1960s, has been challenged by scholars over the past 40 years. For example, as Boyd-Franklin (1989) notes, the assumption that a stable, organized, and psychologically healthy family “must consist of two parents” (p. 15) suggests that any family lacking two parents is inherently pathological. The fact that many African American families are headed by single mothers led some people to conclude that these families must be disorganized, unstable, and psychologically unhealthy. That conclusion is inaccurate, however (Wilkinson & Spurlock, 1986), because it does not take into consideration the roles that factors such as the involvement of the extended family, role flexibility, strong religious
orientation, and strong emphasis on the value of education play in family functioning. These factors are the strengths of the African American family, and therapists should emphasize these strengths in the first and all subsequent therapy sessions to encourage their African American clients’ participation in therapy (Boyd-Franklin, 1989).

Many times, an African American mother in her first therapy session will report that she is a single mother. If the therapist does not explore with such a client the importance of extended family and the client’s definition of her extended family (as discussed in Chapter 2), the client may not reveal to the therapist the existence of important individuals in her life, such as a person who may be a potential stepfather to her children. Knowing about such a person can be important to the therapist, because a stepfather can play an essential role in the development and maintenance of family functioning during the process of psychotherapy.

**Conducting Psychotherapy**

During the first therapeutic contact with an African American client, the therapist must collect preliminary clinical data, and there is minimal emphasis on the psychotherapy process. If the client returns for psychotherapy in subsequent sessions (Chapter 7 summarizes guidelines for the prevention of attrition), the therapist should follow the guidelines summarized below, as recommended in the literature (Baker, 1988; Boyd-Franklin, 1989; Dana, 1993b; Griffith & Baker, 1993; Ho, 1992; Lefley & Pedersen, 1986; Smith, 1981).

**Emphasizing Empowerment**

During the course of therapy with an African American client, it is important that the therapist reinforce the concept of “empowerment,” relating this concept to the client’s experience of therapeutic changes (see Dana, 2002, p. 11). Empowerment is an important concept in therapy with clients from any cultural background, but it is especially important in the case of African American clients because of the long history of slavery, racism, and discrimination experienced by members of this group. When dealing with the concept of empowerment in psychotherapy, the therapist should seek to accomplish two major goals: (a) to help the client gain the skills he or she needs to be able to make important life decisions, whether for him- or herself or for family members; and (b) to help the client develop the skills he or she needs to feel in control of his or her life.

For example, when an African American client is referred for therapy by a welfare agency, the client may experience a sense of powerlessness related to the fact that he or she had no input into the selection of a therapist.
The therapist’s task in such a case is to display sensitivity to the client’s feelings of powerlessness (saying to the client, for example, “I understand that you feel your power of choice has been take away from you regarding the selection of a therapist”) and to make it clear to the client that in the process of psychotherapy he or she will learn specific techniques and skills to deal with such feelings (e.g., problem-solving training and social-skills training).

**Recommended Modalities of Therapy**

**Problem-Solving and Social-Skills Training**

The central goal of problem-solving training is to teach an individual how to solve quickly one or more problems in a series of problems (Kratochwill & Bergan, 1990). Because the therapist teaches the client how to resolve his or her own problems, this strategy may help the client to feel that he or she is regaining power (or control) over his or her own behavior or the behavior of other family members. In general, African American clients (like clients from the other cultural groups discussed in this volume) expect therapists to offer quick solutions to the problems the clients identify as most important (among a set of target problems). Therefore, problem-solving training can facilitate development of the client’s positive perception of therapist credibility (i.e., the client’s feeling that the therapist knows how to treat this particular client and his or her problems) and the client’s sense of trust toward the therapist (Boyd-Franklin, 1989).

The main goal of social-skills training is to teach an individual how to be appropriately assertive in social interactions (Lange & Jakubowski, 1976). As Yamamoto, Silva, Justice, Chang, and Leong (1993) note, many members of non-Anglo-American cultural groups “feel they cannot speak up or assert themselves. Despite improving race relations, [members of such groups] often express that they still feel as if they are second-class citizens” (p. 116; emphasis added). Social-skills training is recommended for African American clients who are not assertive in their interpersonal relationships (including with family members) because they fear negative consequences (e.g., rejection, verbal reprimands) or because they believe that they do not have the right to express their feelings to people in positions of “power” outside the extended family. As Dana (2002) notes, clinicians working with African American clients should consider modifying the interventions they use that emphasize problem-solving training and social-skills training “on the basis of acculturation and racial identity information” (p. 10) (see Chapter 10).

**Family Therapy**

As noted above, the extended family plays a major role in the lives of many African American clients. For this reason, several scholars have
suggested that practitioners should consider family therapy among the first treatment approaches to use with African American clients. All forms of family therapy are recommended with African American families, but two particular tactics are recommended when any form of family therapy is scheduled with African American clients (Boyd-Franklin, 1989, pp. 141–142). The first of these is for the therapist to assign the family members tasks to carry out at home and then report on in subsequent sessions with the therapist. This not only allows the therapist to deal with the problem in the target setting (i.e., at home), it may also encourage those family members who refuse to come to therapy to participate (or at least be more active) in the process of family therapy. In addition, many African American clients enter treatment looking for a “quick fix” for their problems (Boyd-Franklin, 1989), and family members may see the assignment of tasks as an example of the therapist’s interest in dealing with their problems quickly.

The second tactic is the use of role-play scenarios to develop communication among family members. Many African American clients are not familiar with the concept of “family therapy” as something that can help them solve their problems, but only if they elect to communicate with each other. It is recommended that the therapist schedule several sessions in which each family member is encouraged to role-play the way he or she might talk about the target problem at home; through such sessions, the therapist can help all family members understand that they can solve their problems only when they elect to communicate their feelings and concerns to each other. One important consequence of using role playing in family therapy in this way is the reestablishment of a sense of power or control in the family. That is, by learning how to communicate and solve problems through role playing, African American clients can learn that the “powerlessness” or “weakness” they were feeling prior to therapy can gradually be transformed into a sense of empowerment or control. Boyd-Franklin (1989) suggests that the reestablishment of this sense of control should be seen as a fundamental task in the treatment of African American clients with any form of family therapy.

When the goal of family therapy is to deal with the emotional problems of an African American couple (e.g., husband and wife), additional guidelines apply. In general, when a White couple seeks help from a therapist, the partners mutually agree to discuss their problems with the therapist. Among African American couples, in contrast, this level of agreement “is exceedingly rare” (Boyd-Franklin, 1989, p. 225). Boyd-Franklin (1989) suggests that this may be explained by the socialization of African American men, which, influenced by racism and discrimination, has led to the development of the “macho” role, preventing African American men from showing weakness during difficult times. Many African American men may see any admission of emotional problems to people outside the family network as a sign of “weakness.”
Thus, even if both partners in an African American couple come to the first therapy session, the therapist will probably need to develop strategies to encourage the man to return for therapy. Boyd-Franklin (1989) provides a series of general guidelines for therapists seeking to engage African American men in therapy with their partners. First, the therapist should signal to the woman that the therapist can see her alone. Second, it is important for the therapist to explore the woman's understanding of her partner's position with respect to therapy for their mutual problems. Third, although the woman’s presenting her partner with an ultimatum (e.g., “If you do not come to therapy, I will leave you”) may be a good way to get the man to therapy initially, it is important that the therapist help the woman to understand that if the man feels he is being “forced” to come to therapy, he may lose his autonomy and the power to choose his own ways of confronting and resolving the couple’s problems. Fourth, it is important for the woman to understand that it may help if the therapist talks to the man directly; the therapist might explain that he or she does not want to use the woman as a “messenger.” The therapist should consult with the woman to determine a time and day when the therapist can reach the man on the phone; the woman should not inform her partner that the therapist is planning to call him. Because of the generally negative attitude toward therapy among African Americans (which stems in part from the phenomenon of healthy cultural paranoia, discussed above), during their first phone conversation the therapist should tell the man that the therapist has discussed the target problem with the man’s partner (e.g., his wife) and that the main purpose of the conversation is to explore the man’s ideas, suggestions, and understandings with respect to the problem (only the problem the woman has mentioned to the therapist). The therapist should emphasize that he or she needs this information so that he or she can assist the couple (avoiding the word help) in the solution of their concerns (avoiding the word problem).