PSYCHOTHERAPY
with African American Populations:
Modification of Traditional Approaches

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Key Words: demographics, values, diagnoses, culture-adaptive therapy

Abstract

Successful psychotherapy with African Americans requires modifying traditional approaches. The high visibility of skin color is a trigger for racism, which is psychologically embedded and is a socially sanctioned phenomenon in this country. This frequently poses a barrier of distrust between a White therapist and Black patient. Stereotyping may lead to misdiagnosis, inappropriate treatment approaches, and poor outcome. In an era of managed insurance care, health providers need to be specially trained to be culturally competent and ethnically sensitive to the cultural values of all ethnic groups. African Americans have frequently been given pathological diagnoses because of culturally incompetent therapists. Culture-adaptive therapy addresses many of these issues.

Demographics

Persons of color of African descent present high visibility. This tends to obscure social-class diversity among them. There are as many differences as there are similarities among Africans, be they from the Caribbean, West Indies, East Coast of Africa, West Coast of Africa, or the Americas.

This article addresses Africans brought as slaves to America directly from Africa in the 17th, 18th, and 19th centuries. They have been racially labeled over time as Negroes, colored, Black, and most recently African American. Building a country dependent upon the dynamic relationship of slave and master has created a psychic pain and an identity conflict that is unique to African Americans.

In the United States, Asian ethnic groups are increasing in population, while Whites are decreasing. The African American population remains remarkably stable at 12% or about 34 million people. This number does not include an unknown but sizeable number of African Americans who "pass" as White. More than 90% of all African Americans have some mixture of White, Latino, or Native American blood. Of the total population, 34% live in the Northeast and Midwest. A minority live on either the East or the West Coast.

Only 25% earn more than $50,000 per year. The majority still subsist at poverty level, at rates that are double that for the country as a whole, and triple that of the White population.

African American Values

The Black family values the American work ethic, education, property ownership, and belief in supporting the individual within the family who is most likely to succeed. Contrary to popular belief, the Black family is not primarily matriarchal. Where families are intact, the pattern is egalitarian with well-defined roles. In the case of single female heads-of-household, the prevailing model is, of necessity, matriarchal. In these instances, the woman must carry all the roles: breadwinner, parent, nurturer, and problem solver. The survival of the African American family through centuries of systematic and deliberate devaluing of the Black male is due primarily to the resourcefulness, resilience, and intelligence of the Black woman. For African American families, valuing survival meant adapting a mode of functioning based on a present-time concept that differs markedly from other ethnic groups (such as Asian) who value the past and group cultural history, or White ethnic groups who are future-oriented and individually motivated. A recurring theme of conflict in upward mobility for all ethnic groups is the tendency, despite great psychological and social damage to families, for younger generations to place individual values above those of family and group.

The Church and Spirituality

The church is the family of unconditional acceptance. It provides a safe environment physically and socially. The slaves blended western Protestantism with African Spiritism in an ingenious fashion that allowed both to coexist. The church became a refuge and a strength, and a

present and visible representation of all that was embedded in ancient beliefs, mores, customs, rites, and rituals. It became, and still is for the majority of African Americans, the crucible for the collective unconscious of an enslaved people. Faith provided a will to live, forging strength through suffering, the telling of folk tales, oral history of the griots, and a love for every child that yields hope for a better tomorrow. It provides an arena and a platform for those with emerging talents in music, the creative arts, and entrepreneurial areas in particular to be heard.

Internal and External Stressors

The high rates of diseases and other medical conditions, such as obesity, diabetes, hypertension, asthma, stroke, arthritis, sickle cell anemia, and lupus, can be well associated with a lifestyle of poor diet and poor environment, and lack of prenatal care. The tendency to somatize emotional pain into physical illness carries with it a certain amount of empathy and legitimacy among Blacks. It is often interpreted by Whites, however, as "lazy and irresponsible" malingering.

Eighty-three percent of African Americans live in urban ghettos. Within the confines of the inner city are some of the highest rates of social, medical, and psychiatric pathologies. The primary stressor is internal, invisible, and psychological; it is called racism, an omnipresent threat. Like terrorism, racism cannot be easily eradicated because of its unpredictability in who, where, when, and how it will strike. "Black English" has roots as a coded language and is valued as a way to salvage African identity. Creative resourcefulness also exists in literature, art, dance, music, hairstyles, dress, composure, speech, and a myriad of other ways to imprint African culture as a statement of pride in the face of adversity.

Humor is to African Americans what salt is to food. It is the ability to take what is incongruous, a caricature, painful, or illicit and use it to their advantage. Humor serves several purposes at once. Under the guise of entertainment, it can educate or send powerful embedded messages about racism and other social conditions. It can make political statements. It serves as a release from anger, rage, and depression. It is a vehicle of survivalist expression. It is an experience that is difficult to imitate. By poking fun at oneself and evoking laughter, humor provides a conduit to insult and disrespect with impunity. The meaning of humor for Blacks is in the ear of the listener.

Aspiration/Achievement

There is a gap between the perception of aspiration and the goal of achievement for Blacks. Subtle chronic psychic stress occurs when one has to confront embedded messages on a daily basis that all but shout that most consumer goods advertised do not have African American populations in mind.

Socioeconomic Disadvantage

African American high school and college graduates complain frequently that they cannot get a job for which they studied and trained after they graduate. In many instances where jobs are available, advancement is based not on merit but on gender or skin color. Even where money and education are not problems, affordable housing and property ownership keep a majority of Blacks in the ghetto. Racial discrimination in securing loans for a business, education, mortgage, and credit are major psychological stressors. Housing in crowded, poorly maintained rental buildings, with poor air and water quality, noise, pollution, fire hazards, and insufficient space-per-foot-per-person, also produces chronic stress and psychosomatic disorders.

Gender—Males

The male of any cultural group has thrust upon him a proscribed and designated role. In America, that model is that of the successful White Anglo-Saxon Protestant (WASP) male. It is an ascribed role that comes with White identity. For the African American male, racism is a cruel and deliberate oxymoron.

Stress of Success

For the African American male, the cost of success can equal the cost of failure. Many successful African Americans suffer psychological alienation, guilt, and ambivalence for having achieved as an individual. Because racism is based on the profiling of ethnic stereotypes, individual success is often devalued and tokenized. Many choose to pass for White when possible rather than forfeit success.

Mental Health Diagnoses

African Americans are similar to Whites in rates of major psychotic disorders such as schizophrenia and manic depression. However, African Americans are more likely to manifest anxiety, phobias, conversion reactions, and somatic symptoms. Culture-bound symptoms, such as a "staring out," "falling out," "shouting out," and trance-like jerking, fits, and sudden paralysis, are not uncommon, especially in large social groups where emotions run high. The suicide rate among Black youths aged between 17 to 24 years is the highest in the nation.

African Americans represent 40% of the homeless, almost 50% of the prison population, and 45% of the foster care and child welfare population in the United States. African Americans of all ages are more likely to be victims of serious violent crime and physical and sexual abuse, and are also more likely to meet the criteria for post-traumatic stress syndrome, although this is a diagnosis not frequently made for Blacks.

What Do African Americans Do About Mental Health Problems?

Very little. The majority (60%) do not receive care. Fifty percent have no health insurance, and Medicaid covers 21% of those who do. When African Americans do need mental health care, the portal of entry is often through the emergency room. Alternative therapists, such as faith healers, spiritualists, and "root workers," are the first line of intervention, as are home remedies. Contact with mental health services is frequently gained through police, social services, or court services, and disposition is most often hospitalization on an inpatient service or referral to a detox center. African Americans are under-represented in outpatient treatment, but are over-represented in alcohol and substance abuse programs. They are infrequently treated in individ-

ual or group psychotherapy, either in private practices or outpatient clinics. Many African American children and adolescents are treated in residential centers for disturbed youth.

The Mental Health Service Community Response to the African American Psychiatric Population

The mental health service community responds to the African American psychiatric population inadequately and often inappropriately. Numerous studies confirm that when seen for evaluation or treatment, African Americans continue to be over-diagnosed with alcohol/substance abuse, antisocial personality, or schizophrenia. They are over-medicated with high-dose neuroleptics, are discharged without adequate follow-up care, and are under-diagnosed for depression, post-traumatic stress syndrome, and anxiety disorders. They are less often given Selective Serotonin Reuptake Inhibitors (SSRIs) and benzodiazepines.

Barriers to Treatment, When Treatment Is Available

Myths, negative attitudes, and racial biases persist. Many African Americans believe that even when they have insurance coverage, White health care providers do not want to treat them and will only give them pills that will make them worse. Further, "if talk therapy is all they are going to do, they can talk to their friends, family, or minister." African Americans only go to psychiatrists if they feel they are "really crazy." Being crazy is a stigma to be avoided in the African American community. African Americans continue to feel White mental health care professionals are a real part of their problem, not their solution. This high level of suspicion is not without some basis in reality. The story of the Tuskegee Experiment is common knowledge amongst Blacks. This refers to the infamous research conducted by the U.S. government on a large number of Black males who were deliberately deprived of treatment for syphilis in order to study the natural progression of the disease to termination. There are parallel events regarding young Black women assumed to be retarded without testing who were sterilized without their consent or knowledge. No matter how well-intended, the healthcare offered is tainted with distrust. This contributes to being labeled paranoid. The response of the treating professional often matches that of the African American patient. The clinician tends to stereotype, patronize, depersonalize (i.e. treat the symptom, not the person), and in feeling resistance or lack of engagement, reacts with a summary judgment that the patient is either unwilling or unable to use the service, and further does not have adequate insurance to cover treatment even if he or she could use it. Psychological education or even simple feedback is rarely given. The mental status examination is as brief as possible: Evaluate, diagnose, prescribe, and refer out. I do not like you and you do not respect me. Next!

Psychotherapy

General principles: A good therapist is one who is first comfortable with his or her own identity and competence and who is there for the patient. This means providing an open, receptive, emotionally safe environment. Listening to and being supportive of the patient is critical to a positive outcome, regardless of diagnosis.

Specific Therapies: The choice of what treatment(s) to prescribe for which patient is a clinical decision of the utmost importance. All persons who present for treatment with problems of emotional pain want relief from psychological distress. There are many paths to that goal. Culture-adaptive therapy is one that promises to be of special value to individuals with acculturation problems, be they recent immigrants or citizens living in America for several generations. Through the use of family history, story-telling, descriptions of personal and family rituals, proverbs, metaphors, and local knowledge, Culture-adaptive therapy offers an opportunity to understand how the person's cultural/ethnic identity relates to problems in current psychosocial function.

Goal Attainment and Cognitive Behavioral Therapy: Homework focused on patient-idealized specific pieces of problematic behavior, where change can be concretely measured by the patient, can be very effective.

Psychoeducation: Involving the patient in a treatment contract and educating the patient to become an informed consumer regarding medications, side effects, dosages, and availability of other treatments is important with Black patients in regard to their compliance and outcome. It is equally important to provide education about what other medications or alternative therapies may be harmful or helpful. Common everyday lay language is preferred to professional jargon.

Role Relationship Therapy: The therapist 1.) Listens empathically and gives practical, concrete, and do-able what-to, how-to advice in a respectful fashion; 2.) Pays particular attention to setting, time, space, boundaries, and limits; and 3.) Observes and mirrors positive body language. This can empower patients to internalize new behaviors that generalize to higher-level social functioning. Couples, families, and significant others should be included in this process when possible, as exclusion may jeopardize treatment outcome. The focus at each session should be on present, here-and-now status. Patients should leave with a sense of having been heard, and should have something specific to take away with them. Evidence-based affirmations at each session are welcomed, as is acceptance of cultural insights and information.

Follow Up

The expected course, time frame, and prognosis should be explained and incorporated into the treatment plan at the outset. Explaining the reason and importance of follow-up treatment enhances the patient's sense of being valued and contributes a great deal to successful outcomes. Follow-up treatments should be scheduled at monthly and 3-month intervals.

Complications/Risks

Misdiagnosis, failure to get family history and other medical history, failure to explain and obtain informed consent, and failure to contact significant others can lead to psychiatric sequalae and legal and ethical problems. Personalizing and making untested assumptions about a patient's presentation results in counter transference and incompetent treatment.

One of the mandatory questions in the first interview is "Why now and why me?" The reply with African Americans of any age or gender is typically "I've tried therapy in the past or avoided it," or "I know I need it and can use it, and you will understand that when I say 'My mother wasn't there for me and had to work two jobs,' I don't have abandonment issues, or that when I talk about how many times we moved it doesn't mean I haven't experienced object constancy or stability." Most Black patients report that therapy is not a safe emotional environment for them, and they fear that their external situations will be interpreted as indicators of personal inadequacy. In brief, they are made to feel shame. One Black female resident in psychiatry supervision with me asked why it is that when Kim Basinger wears her hair in cornrows it's "chic," but when she does, it is "primitive."

Recommendations

I strongly recommend that all medical staff, especially medical students and residents in psychiatry, be trained to be culturally competent and ethnically sensitive. Familiarity with DSM-IV appendix cultural formulation is essential. Close interaction and cross-fertilization with other disciplines in sharing information and resources, especially community and faith-based resources in the patient's neighborhood, will go far in protecting the therapist's clinical investment.

Culture-adaptive therapy does not change the basic definition of psychotherapy as a dyadic dynamic process of working through conflicts based on transference. Cultural adaptive therapy allows a rational and different conceptualization of transference that makes possible effective treatment of African Americans and other culturally diverse individuals.

The aftermath of terror caused by the terrorist attacks of 9/11 had similar effects on the United States as World War II did. It created an equal opportunity for all people, regardless of race, to come together to find a way to live together or perish. Managed care insurance providers not withstanding, many deficits have made healthcare available to more of the employed than ever before. Employment Assistance Programs are more aware than ever before that emotionally disturbed employees are not only unproductive, but are also a liability. Employers are now insisting that employees for whom insurance is provided be productive and get help or get out. Health care providers are discovering that if they want to stay in practice with managed-care companies, treatment has to have a uniform protocol based on standards, not stereotypes. And so it may come to pass again that Ben Franklin's adage that "we all hang together or we hang separately" makes survival colorblind.

Conclusions

People return to treatment when their needs are met. Well-known professionals in the field of cultural diversity, such as Stanley Sue, Monica McGoldrick, and Ramon Rojano are united in advocating diversity training, mentoring, and recruitment. They cite studies showing that people of color return to treatment when their needs are met.

Saint Vincent Catholic Medical Centers–Manhattan, where I have worked for 37 years in the Department of Behavioral Sciences, is in the heart of Greenwich Village, a cultural mecca and crossroad of the world. Over the years, the hospital has expanded its services to diverse populations, including Asians, Latinos, Russians, and Africans, in much the same way that services have become integrated for children and adolescents and geriatric and forensic patients. I am extremely optimistic that professionally we are more aware than ever of the needs of minority patients and how to better serve them.

References

American Psychiatric Association. (2001). Appendix I: Outline for cultural formulation. *Diagnostic and statistical manual - text revision* (DSM-IV-TR™, 2001). U.S. Department of Health and Human Services, Office of the Surgeon General, SAMHSA.

GAP- Report No. 145. *Cultural assessment in clinical psychiatry*. Washington, D.C.: APA Press.

Hughes, L. (1961). *The best of simple.* New York: Hill and Wang.

Jones, J. H. (1993). *Bad blood: The Tuskegee syphilis experiment.* New York: Free Press.

Mayo, J. (1999). Culture adaptive therapy. In H. Rebach & J. Bruhn (Eds.), *Handbook of clinical sociology.* New York: Plenum Press.

Mayo, J.A. (1971). *The new Black feminism. A minority report in contemporary sexual behavior.* J. Uburn & J. Money (Eds.). Chap. 9. Baltimore: Johns Hopkins University Press.

Mayo, J.A. The significance of sociocultural variables in the psychiatric treatment of Black outpatients. *Comprehensive Psychiatry, 15*(9-10): 471-482.

Waters, R. (2003, September/October). The diversity gap in psychotherapy. *Psychotherapy Networker*.

Wen-shung, T. (2001). *Handbook of cultural psychiatry.* San Diego, CA: Academic Press.

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