CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

TRUST: Therapeutic Relationships with African Americans

Clinician Handbook

A graduate project submitted in partial fulfillment of the requirements

For the degree of Master of Science in Counseling,

Marriage and Family Therapy

By

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December 2016
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ACKNOWLEDGEMENTS

I would like to thank my father, Dr. Phillip Walker, for his love, support, and expertise. His guidance has been invaluable in helping me along my journey towards completing the MFT program and this project. I would also like to thank my mother, Carolyn, whose prayers and spiritual insight has strengthened my spirituality, and my belief in my creator. I am grateful to my wife, Karine. Her support, and sacrifice has made my dreams of continuing my education become a reality. Without her support and unwavering sacrifices, this project would not have been possible.
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ABSTRACT

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This research project focuses on the underlying issues related to mistrust of the whole health care system among African Americans. It explores several issues which include: the African Worldview on African Americans, a history of racism and discriminatory practices; the psychological over-diagnoses & under-diagnoses of African Americans, the stigma associated with mental health; and distrust of European treatment models. This project has been created as a guide to establishing trust in the therapeutic relationship between the clinician and Black client.
CHAPTER I

Introduction

“Mental health is predicated on us remembering our past … Often the oppressed cannot forget their hurts, wounds, and nightmares, shared suffering is simply all they’ve got.”
-----Phillip Walker, Ph.D.

Background of Problem

The quote by Dr. Walker is based on the notion that "mental health is predicated on us remembering our past." Therefore, the hurts, wounds, and nightmares" of oppression become normalized as "shared suffering." Shared suffering refers to the existential reality of social, political oppression experienced by African Americans. The psychological or emotional pain associated with African American oppression in the United States, both historically and currently, has created resistance to utilizing health care services especially psychological. This project considers mental health as a part of health care, although they are often undifferentiated due to a mechanized view. Some African Americans associate mental health services with health services; many view it as one system. Consequently, there is an aversion and distrust of the whole system; it’s not designed to serve them.

Mental health treatment models are further distrusted because they often lack adequate cultural relevance. Current models are based on White patients who are insightful, verbal, and share similar values as the therapist. African Americans, by definition, often resist the idea of mental health services because they are irrelevant to their needs; cultural relevancy is questioned. In a sense, "shared suffering" is used as a defense against health care services because of distrust.
“The idea of “shared suffering” is commonly played out in society where strangers are referred to each other as "brother," reinforcing “we against them” attitudes.

To have a better understanding of Black resistance to health care services, it is critical to acknowledge the large void of professional African American mental health workers and clients. Professional mental health workers are not adequately represented based on demographics of the American population: Blacks are represented. This is detrimental to both the African American community and mental health networks. Questions that must be answered are:

- What are the issues associated with the mistrust of the health care system by African Americans?
- Which factors influence the mistrust?

To answer these questions, this project will follow a qualitative research model aimed at defining and understanding the obstacles that prevent African Americans from seeking mental health care.

Studies have been published on the concept of cultural mistrust. These studies are based on William H. Grier and Price M. Cobbs notion of Cultural Paranoia which was featured in their highly popular book Black Rage. Grier and Cobbs suggest that cultural mistrust is a paranoid-like-response style in African Americans. The Cultural Mistrust Inventory developed by Terrell and Terrell (1981) measures African Americans lack of trust at the cultural level. It assumes that racism and oppression in the past and present are primary factors, which influence cultural paranoia in the form of mistrusting Whites. Joseph Heller, an American satirical novelist, short story writer, and playwright, once said: “… because you’re paranoid doesn’t mean they aren’t after you.” Racism leads to lack of trust, imprinting itself into the cultural memory of African
Americans. This cultural memory is the result of slavery, Jim Crow, MAAPA, the KKK, lynching, and today’s racism embedded in America’s institutional and social structure.

This paper theorizes that there is a strong association between cultural mistrust and the attitudes towards counseling among African Americans. Clients with low levels of trust view the expectations of White counselors negatively based on cultural paranoia.

**Purpose of Project**

The primary purpose of this project is to understand Black’s low distrust of the mental health system. Secondarily, the goal is to help therapists with diverse cultural backgrounds build successful therapeutic relationships by addressing inherent trust issues caused by racism and economic distress.

**Statement of Need**

African Americans are afflicted with similar mental health issues as other groups. Distrust of the system discourages the utilization of available resources. Blacks will continue to resist mental health services unless they perceive greater relevancy to their needs.

**Definitions and Explanations of Key Terms**

- **Health Care System**: The organization of people, institutions, and resources that deliver both mental and health care services to meet the health care needs of target populations.
- **Healthcare**: The maintenance and improvement of physical and mental health, especially through the provision of medical services.
- **Racism**: The belief that all members of each race possess characteristics or abilities specific to that race, especially so as to distinguish it as inferior or superior to another race.
• **Cultural Mistrust:** According to Grier and Cobb (1968), it is a paranoid-like-response style in African Americans.

• **Discrimination:** The unjust or prejudicial treatment of different categories of people, especially based on the race, age, or gender.

• **Stigma:** A mark of disgrace associated with a particular circumstance, quality, or person.

• **Inferior:** Lower rank, status, or quality.

• **Mental Health:** A state of emotional and psychological well-being where an individual is able to use his or her cognitive and emotional capabilities, function in society and meet the ordinary demands of everyday life.

• **Holism:** Holism is the idea that systems (physical, biological, chemical, social, economic, mental, linguistic, etc.) and their properties should be viewed as wholes, not as collections of parts. This often includes the view that systems function as wholes and that their functioning cannot be fully understood solely in terms of their component parts.

**Limitations of Project**

Research is very limited on the relationship between trust and African Americans in a therapeutic setting. Therefore, this project is an extrapolation of results from many sources on trust. It contributes to understanding the relevance of trust in establishing therapeutic relationships with African American rather than establishing any causal relationship; data is very limited on cause and effect. This is a qualitative study restricted to a literature search or analysis of texts, including direct observations. An experimental design was not utilized.

**Organization of Project**

This project is organized into four chapters, which includes a References section, and the Appendix.
Chapter I Introduction Includes:

- Background of the problem
- Purpose of the Project
- Statement of Need
- Definitions and Explanations of Key Terms
- Limitations of the Project
- Organization of the Project

Chapter II Includes Review of the Literature:

- The Africans Worldview’s Influence on African Americans
- History of Racism and Discrimination
- Tuskegee Syphilis Experiment
- Over Diagnoses & Under Diagnoses
- Stigma Associated with Mental Illness
- Distrust in European Treatment Models
- Economics of Scarcity

Chapter III Includes:

- Introduction to the Workbook

Chapter IV Includes:

- Recommendations
- Summary
CHAPTER II

Review of the Literature

The African Worldview Influence on African Americans

The concept of holism provides the framework for Black beliefs and values. (Parham, White & Ajamu 2000). There are several dimensions within the African Worldview which influence African American behavior and habits.

Some include:

- **Spirituality**: the belief in a being or force greater than oneself. In the United States, it is seen in religious worship and rituals such as attending church, prayers, and celebration of religious holidays. African Americans are more likely than European Americans to report religious beliefs. They are also more likely to use spirituality as a framework for coping with stressful circumstances such as chronic illness and disabling conditions (Belgrave, Allison 2006).

- **Collectivism**: this reinforces interdependence, cooperation, and the motivation to work for the survival of the group rather than that of the individual. The collective orientation is reflected by saying, “I am because we are; and because we are, therefore I am. In African American culture, the experiences of the individual influence the experiences of the group, and vice versa. This collective orientation is reflected in African Americans by their frequent contact with the immediate and extended family, the tendency of family members to live near one another, and the care provided for elderly and disabled family members (Belgrave, Allison 2006). Another example is when a member of the African American community has been wrongly persecuted, imprisoned, or murdered by police. Members of the Black community say, “look how they are treating us.”
• Time Orientation: Western culture is future oriented; it is seen as mathematical and bound by the clock. Future time orientation is reflected in Western psychology’s emphasis on prediction and control. In contrast, Africans see time as flexible, it exist to meet the needs of the people. Time within African culture considers the past and present to be of equal importance as the future. Because of these differences, African Americans have been labeled as deficient because of a lack of futuristic time orientation and not having the ability to delay future gratification. For example, there is a cliché among African Americans known as Colored People’s time (CPT). This means that arriving late is acceptable, or time must be experienced to be valid (Belgrave, Allison 2006).

• Death: is seen by Euro-Americans as the “end of life” and the body’s end. They see the urgency to preserve life, and avoid the realities of getting old. In the African Worldview, which is embraced by African Americans, death is seen as another transition from this life into the next (Belgrave, Allison 2006).

History of Racism and Discrimination

Ethnic and racial minorities, including African Americans, experience more instances of racial discrimination in the healthcare system, and have reported less satisfaction with the quality of care and a higher extent of mistrust in the system, compared to their white counterparts (Corbie-Smith, Thomas & Williams, 2002). Disease prevention and healthcare intervention among Blacks is a significant area of study given the high number of medical issues that disproportionally affect African Americans. In examining the issue of race consciousness, Watts (2003) emphasizes the significance of appreciating the complex historical journey of the African American population, self-appraisal of the attitudes, beliefs, feelings and biases towards individuals of color, and the disparities in health that optimal levels of care for African
Americans. She traces the mistrust in the healthcare system to the institution of slavery and the dehumanization that started about four centuries ago. From about 1619 to the present day, African Americans have faced turbulent periods of segregation, slavery and discrimination. Racial inequalities are reflected in historical records, biographies and slave narratives that characterize Black slaves as individuals who lacked feelings, intelligence and character. In addition, early Supreme Court rulings (Separate But Equal - Plessy v. Ferguson, 1896 and The Three-Fifths Compromise - Dred Scott v. Sandford, 1857) further fostered lack of trust in America’s social institutions. The adoption of harsh laws played a fundamental role in perpetuating the oppression of African Americans, and reinforcing the belief that Blacks were inferior (Watts, 2003). In order to show how historical factors contribute to low trust in the healthcare system by Blacks, Watts (2003) cite a report by the Commonwealth Fund that examined health care quality provided for minority Americans. The telephone survey involved 6,722 ethnic and white minorities (Hispanics, Asian Americans and African Americans). The results revealed inequality in healthcare quality in four major areas: cultural competence in the access to care; provision of care; and quality of care and patient-physician communication.

Another study by Kelsey, Lawson & Tanya (2013) contends that the feelings of vulnerability, mistrust and suspicion towards the healthcare system among the African Americans can be attributed to a history of medical experimentations on the Black community. These findings are corroborated by research by (LaVeist, 2000; Corbie-Smith, Thomas & Williams, 2002) showed that African Americans as more suspicious of governmental and private health care institutions due to past discriminatory events and the negative healthcare experiences. The knowledge of exploitation and dehumanization of Black Americans in health matters has been passed on through personal story as well as historical documentation of medical
experimentation on this population. Results of the community-based sample by LaVeist (2000) showed that 70 percent of the African American population believed the government was not disclosing to them crucial information about HIV and AIDS. Watts (2003), emphasizes the need for clinical studies to continue exploring the levels to which multidimensional factors, including cultural beliefs, biological variations, behavior and socioeconomic status, contribute to healthcare disparities.

**Tuskegee Syphilis Experiment**

According to Kelsey, Lawson & Tanya (2013) and Corbie-Smith, Thomas & Williams (2002), research shows that the medical mistrust among African Americans stems from historical events such as the Tuskegee Syphilis Study. This controversial non-therapeutic experiment was carried out between 1932 and 1972, and involved human rights abuses, and violations that depicted social experimentation and medical research at its worst. The U.S. Public Health Service (USPHS) sponsored the Tuskegee Study to review the spread of syphilis infections in the rural south and find out whether it was possible to conduct mass treatment (Baker, Brawley & Marks, 2005). During the 1920s, about 37 percent of the residents of Tuskegee were suffering from syphilis. Baker, Brawley & Marks (2005) note that 82 percent of the residents of Tuskegee were African-Americans, and this population was the main target of the investigation. At the time of the study, syphilitic complications were viewed to be influenced by race, leading to the assumption that neuro-syphilis was more common among the whites, while cardiovascular disease was more prevalent among the Blacks and overall complications were more common among whites compared to African Americans.

Heintzelman (2003) also examines the relationship between the Tuskegee Syphilis Study and the mistrust in the healthcare system by African Americans the 21st Century. The article
maintains that the UPSHS used deception to recruit the participants, and overlooked patient welfare by withholding treatment based on the assumption that non-treatment was more beneficial than treatment. Those conducting the study took advantage of the low socioeconomic and educational levels of African Americans, and their willingness to participate in a study that they had been informed would be of great significance to them. The participants received medical follow-up including blood tests, lumbar punctures and physical examinations, although no specific treatment was administered. The investigators informed the men that tonics, vitamins and aspirins would cure syphilis and that they would receive the free treatment if they accepted to participate in the study. The main aim of the investigators was to evaluate the level of medical deterioration that would occur overtime among individuals with untreated syphilis. Although the original time frame of the study was 6 to 8 months, the investigators extended the study for 40 years. They conducted follow up until the eventual death of the participant and the subsequent postmortem examination (Heintzelman, 2003). These events created the reality of a healthcare system that was only concerned about advancing its own needs by exploiting the minorities.

According to Bates & Harris (2004), the impact of the Tuskegee Study marked the beginning of low trust of biomedical research for Blacks. Their research findings indicate that the reforms made in biomedical research are not enough to convince the African-American public that “another Tuskegee” will not occur. However, this article also acknowledges that African Americans may participate in biomedical research studies if they recognize that doing so would help develop effective and safe medications. Jacobs et al (2006) conducted a study to better understand the effect of low trust and trust in physicians by African Americans. The focus group study utilized an open-ended discussion involving African American adult women and men. The factors contributing to distrust in physicians include the expectations that the caregiver
will conduct experimentation during routine provision of care. Given that trust promotes patient adherence and honesty and facilitates care-seeking behavior, the expectations of experimentation deter the involvement of African Americans in the healthcare system.

**Over Diagnoses & Under Diagnoses**

There are limited cases of misdiagnoses caused by racial or cultural differences such as cultural misinterpretations, language differences and patient distrust. There have been discussions on the historical underpinnings and the possible impact of the black community’s distrust in the healthcare system, little research has been conducted to understand how the distrust influences the current views of African Americans relating to the trustworthiness of physicians. Harold provides an analysis of studies of misdiagnosis among the African American population. The investigation found mixed results as the background of the patients did not have an effect on diagnostic outcome in some studies while other researchers showed that correct diagnoses were given when there was no identifying information on the patient. A study by Whaley (2002) evaluate cultural biases in the diagnosis of African American psychiatric patients found that the assumptions concerning cultural mistrust among the overall African American population can be applied to individuals with chronic mental illness. Some African American physicians hold the view that self-labeling as “African American” creates better mental health and greater political consciousness.

A notable study cited in Harold (n.d) by researchers Lawson, Holladay, Hepler and Cuffel (1994) utilized a precise measurement of “over-diagnosis” by comparing the number of minority outpatients and inpatients to the overall number of minority patients in the whole mental health system. While only 16 percent of the populations were Blacks, they constituted 37 percent of schizophrenic outpatients and approximately half the number of diagnosed inpatients.
This statistical pattern is consistent with the results of prior studies that show a significant link between diagnosis and ethnicity, although the available information remains provocative and requires more definitive explanations.

Francis, Russell & Mezzic (2015) in their assessment of the differences in the diagnosis of individuals from different cultural groups found the need to develop culturally competent attitudes, skills, and knowledge in order to avoid misdiagnosis and bias. The diagnosis of minority patients is more complex than non-minority patients, especially when the clinician belongs to a different ethnic group. Besides that, the guidelines of the American Psychological Association acknowledge the need to assess individuals based on their cultural and ethnic background, respecting their practices and beliefs, assessing the support system of the patient and taking a history to account for acculturation and immigration stresses.

**Stigma Associated with Mental Illness**

Ward & Heidrich (2009) cites that about 7.5 million Blacks have been diagnosed with a mental illness and approximately 7.5 million more could be affected, although they are still undiagnosed. Although the number of African American women burdened by mental illness is high, most of them do not use mental health services. The author identifies stigma as a significant barrier to their use of mental health services. Also, among some African Americans, avoidance of the mental health systems can be blamed on the potential for intensified prejudice, discrimination and stereotypes (Braithwaite, Taylor & Treadwell, 2009). Stigma among family members of individuals with mental illness, and attribution of mental problems to attitudinal and cognitive issues instead of biological or medical etiology is a major cause of treatment non-compliance. According to The Surgeon General Report, stigma is a chief obstacle to receiving and consuming metal health services among ethnic and racial minority populations (Braithwaite,
Taylor & Treadwell, 2009). Having faced discrimination and prejudice for so many years, these racial minority groups experience a double stigma when suffering from mental illness. The issue of “double stigma” is considered an added burden to ethnic minorities in the U.S. but it affects different cultural groups in different ways. Particularly, a double stigma among the Blacks encompasses maltreatment, lower socioeconomic status, distrust of the medical establishment and misdiagnosis.

Given that stigma is largely influenced by culture, it is assumed the beliefs, attitudes and knowledge that underlie stigma are different for African Americans, Asian Americans, whites and Latinos. To support this claim, Ward & Heidrich (2009) cites research by (Van Hook, 1999; Bell and Baker, 1999) that showed that stigma has a negative effect on mental health treatment-seeking behavior among African Americans. In addition, the stigma associated with mental disease deters medication compliance. Studies such as (Van Hook, 1999; Bell and Baker, 1999; Ward & Heidrich, 2009) show that the mental illness stigma results in patient’s discontinuation of their medication use. Many individuals avoid using medication out of fear of being labeled “psychiatric patient.”

Distrust in European Treatment Models

According to Ball, Lawson & Tanya (2013), a history of medical experimentation and exploitation of Blacks has resulted in feelings of vulnerability, mistrust and suspicion towards medical establishments. Participants in research carried out by Corbie-Smith, Thomas & Williams (2000) expressed concerns about benefiting from medical research findings. They cited that they were less likely to benefit due to racial discrimination or the inability to afford services. In the same breath, research shows that the deep mistrust of physicians by African Americans has been linked to noncompliance, dissatisfaction and underutilization of health care services.
Blacks who don’t trust health care organizations and physicians have more negative expectations of medical establishments compared to Blacks who do not distrust the health system. This is illustrated in a study by Bogart et al (2010) which involved 214 HIV infected Black men. The researchers’ main objective was to establish whether a specific form of mistrust, such as HIV conspiracy beliefs was associated with non adherence to HIV treatment among African American men. Confirmatory Factor Analysis revealed that conspiracy beliefs, such as genocidal beliefs (HIV is manmade) as well as treatment-related beliefs (individuals who take antiretroviral medication are the government’s human guinea pigs), contributed to the mistrust in the healthcare system. These views were related to non-adherence to antiretroviral treatment hence they show that medical mistrust hampers appropriate treatment behavior.

Racial and ethnic differences in rates of non-adherence to treatment recommendations have been examined. For example, a study by Gardon, Paterniti & Wray (2004) involving direct observation of doctor-patient interaction was aimed at examining the willingness of patients of diverse ethnic backgrounds to adhere to the doctor’s recommendations. This study found that Black patients were more likely to decline a recommended angiogram than white patients. The authors indicated that the results of study were consistent with the findings of previous research that employed indirect methods to assess patients’ adherence. The findings led to the conclusion that the quality of the interaction between the doctor and patient is likely to influence the recommendations made by the doctor and the patient’s refusal. The researchers added that successful doctor-patient communication allows the patient to negotiate and discuss their preferences for therapeutic and diagnostic procedures. They also noted that communication may be more effective if the patient and doctor are of the same racial background. Their findings
corroborated prior studies that employed hypothetical scenarios, and found that African American patients were less likely to accept recommendation of cardiac catheterization, bypass surgery, angioplasty or carotid endarterectomy compared to their white counterparts. This shows that patient preferences largely contribute to ethnic and racial disparities in healthcare. However, the same study also suggests that patient preferences are not the main causes of observed disparity in care, and that there are other sources of disparities that should be examined. Likewise, their results reinforce the revelation by a number of prior studies that patient refusal of recommended invasive procedures does not occur frequently. As such, the low number of patient refusal creates the need to focus on other possible influences in doctor-patient interactions (Gardon, Paterniti & Wray, 2004).

Also, most African Americans do not trust the European treatment models, and thus they seek support and healing from God or often spiritual healing. As noted by Bigby (2003), many low income African Americans separate illness into two areas (1) natural illness that occurs due to God’s will, or when an individual is exposed to some forces of nature such as impurities in water, food or air, and (2) unnatural illness that results from evil influences that interfere with the God’s plans. Those who embrace this notion believe that natural illness is cured by an antidote and similar logical protective actions. The belief in unnatural illness is rooted in the idea that such illnesses are caused by witchcraft, whereby some individuals have the power to mobilize good and evil forces. As such, treatment for unnatural illness is found in magic, herbs, religion and amulets. Most of these beliefs are attributed to the African culture, and aspects of them are evident among African Americans of different backgrounds (Bigby, 2003). The feelings of mistrust in health care may lead to a series of self-destructive and maladaptive behaviors that
may stifle treatment, and prevention efforts within the African American population (Braithwaite, Taylor & Treadwell, 2009).

Economics of Scarcity

It is difficult to disentangle socioeconomic status and ethnicity. When explaining the differences between whites and African Americans, the first step is to consider the effect of white-black socioeconomic and demographic differences. Survey findings show that even among Blacks who are working, high rates of poverty and high insurance rates continue to hamper access to care (Tenney, Collins & Hughes, 2002). Also, the findings reveal there are major differences in access to mechanisms that defray costs such as insurance. Further, a high number of African Americans aged 50 years or older are living with chronic disease, and this suggests that there are high levels of severity of diseases among Black patients. Research by Newsom & Becker (2003) found that low socioeconomic status is a significant determinant of access to professional health care. In their qualitative interview of 60 Blacks who were suffering from one or more chronic diseases, low income respondents were highly dissatisfied with the health care system than their middle-income counterparts. Newsom & Becker (2003) also note that racism has been a hindrance to socioeconomic attainment for African Americans. In fact, the authors cite that race is a determinant of socioeconomic status, and that the racial differences in socioeconomic status reflect the successful adoption of discriminatory policies that target minority groups.

When discussing poor health status of the African American population, Bigby (2003) cited that it is significant to analyze the larger causal mechanism that considers discrimination as one of the factors regardless of the economic status. Poor health status among Blacks dates back to slavery, given their inadequate access to nutritional diet and care. The author argues that
African Americans of all economic levels face discrimination in health care. She further cites a Commonwealth Fund Report that indicates that Blacks are often disrespected in health care settings (Bigby, 2003). However, the same researchers maintain that the economics of scarcity alone cannot account for the mistrust in the health care system by African Americans; mistrust is a societal issue. Despite differences in geographic distribution, socioeconomic levels and age groups, African Americans hold similar health practices and beliefs. Although African Americans are a diverse population, their lifestyle is more similar due to cultural and historical influences. Stable and well-grounded social support networks, mistrust of the health system, fears related to cancer, and seeking information from informal health care systems are common themes when looking at the issues of mistrust in the health care system. For a long time, Blacks have used religiosity and prayer to treat and cope with health concerns. Both Bigby (2003) and Ward & Heidrich (2009) indicate that African Americans prefer to seek psychological and spiritual support, which often leads to delays in seeking help from medical establishments. The issues of today’s health care system revolve around the interplay of the political, social, legal and economic aspects of the American community. Since the patient has to put his or her health in the hands of their healthcare provider, a certain level of medical reliance and dependence is inevitably created. Researchers have pointed to a wide range of discriminatory events in history that have perpetuated mistrust among African Americans.
CHAPTER III

Introduction to the Workbook

This workbook is intended to help counselors and therapists of different races and nationalities build trust in the therapeutic relationship between them and African American clients. The goal is to also challenge biases and unwarranted assumptions about African Americans, and focus on trends affecting them negatively in the healthcare system.

Block (1980) suggested three trends relative to Blacks in psychotherapy. For the first trend, Blacks were depicted as persons limited in cognitive, emotional, and social abilities who were, or should be, content with their low status because of their relative immaturity compared to the dominate white culture. According to Block, this led to higher character disorders among Blacks. The second trend started to take shape around the end of World War II, when a large number of service members were being treated by white therapist. The psychological literature back then focused on Blacks’ suspicion, hostility, and distrust of White therapists, and their preoccupation with discussing racial issues during therapy sessions. According to Block, these characteristics were interpreted by therapists again with some type of psychotic disorder. The third trend was during and after the Civil Rights/ Black Power era, and shifted to an acceptance of the need for Blacks to develop different defensive coping styles to handle their environmental realities. Racial consciousness, ager, and distrust could now be viewed as appropriate and adaptive behaviors. These characteristics were being proposed and validated by Black, and other minority psychologists.
CHAPTER IV

Summary and Recommendations

To work effectively with African American clients and to build trust, therapists must develop and integrate an Afro-centric perspective into their approach. They must come to grips with historical and current socio-economic issues that rob Blacks of their willingness to seek mental health services. This means establishing a personal comfort level and commitment with a Black Worldview. To facilitate this type of social enlightenment, therapists must identify and study a broader base of knowledge concerning the psychology of Blacks and socioeconomic influences. Learned social enlightenment can serve as a basis for establishing effective therapeutic relationships and high trust that attract and serve people of African descent.

Furthermore, enlightened therapists can act as change agents in the Black community by promoting greater levels mental health and wellness. As a prerequisite, therapists must be willing to integrate African-centered principles into their own lives. This happens by virtue of embracing African-centered life-affirming principles that emphasize both social bonding and wellness. This means that therapists must understand and be sensitive to Black shared suffering and culture.

White (1984) and White and Parham (1990) suggested several recommendations in order to increase the effectiveness with African American clients. Therapist need to be cognizant of four major issues: (1) the impact of oppression on the lives of Blacks; (2) African American psychological perspectives as a source of strength; (3) African American language styles (to facilitate communication); and (4) identity concerns that arise as result of an admixture of African American and Euro American influence. Therapists who plan to work with African American clients must familiarize themselves with these issues.
References


APPENDIX

How to Build Therapeutic Trusting Relationships with African American Clients

Therapists Guide

*This Therapist Guide is designed to help you build strong therapeutic relationships with African American clients. While it is not intended as a compendium of techniques, it does offer a conceptual framework for working more effectively with African American clients.*

This guide covers areas that support therapists of all races and nationalities working effectively with African American Clients. It includes a structural model developed by Sue, Arredono, and McDavis (1997) that highlights **awareness** with a focus on overcoming biases and the MAAFA (see definitions of Key Terms), **knowledge**, and **skill** dimensions of cultural competency for African-centered psychology and therapy. In addition, a Resources Section includes: literature, Black churches, and a video on diversity and multicultural issues that increases effectiveness of working with Black clients.

To remedy biases and to increase understanding of psychotherapy for Blacks, therapists will find the following information helpful:

**Awareness**

- Therapists must be cognizant of his or her personal biases and assumptions about African descended people. There are two parts to overcoming your hidden and unconscious biases:
  
  1. Understanding Biases

     ➢ **Consider various ways you can gain insight into your bias.** Biases affect us all in ways we seldom realize. We may see ordinary, happy people living their
day-to-day life in all kinds of environments, but they all have a bias of some kind, which is directing their intentions. Biases can be positive or negative aspects of human nature; they all influence how we act and interact with other people and events. It is important to examine our biases, because the way we create biases is the same process for both mild and severe ones.

- **Explore the dynamic of biases.** Meditation is a good way to investigate your bias, as well as how your mind acts in relation to them. Meditation also helps to better understand how they get created. Another good method is to discuss it with a friend, counselor, or a psychologist.

2. Working on Biases:

- **Recognize that a specific bias exists.** This is the beginning stage to enable you to overcome it. If you can, this means admitting there is a bias, as in admitting it versus just thinking there is a bias. Often, this is very difficult for most people to do honestly, as it is somewhat of a humbling act. But, doing this will help you to explore it, as you are prepared to be more open. By recognizing your bias and what it relies on to stay in the mind, then you are one step closer to getting rid of it.

I. **Consider why it is difficult to remove biases.** There are often three main problems at play. You often feel distant and uncomfortable with the fact that the object of the bias simply exists. This can be because you don't actually know anything about the focus of your bias. You might have negative stories about your biases, but how much of that is true or relevant?
II. As you identify with your prejudices, it can feel like you are surrendering part of yourself, or betraying your cultural identity for someone else. These issues are often the main cause of why many are reluctant to overcome their bias. Of these problems, the exact same question has to be asked as that of the bias—is it causing you more harm than good?

III. You may feel you have a bias, but have not really come to a conclusion that it should be abandoned. Consequently, many parts of your mind will struggle against overcoming them as the bias is still attractive to certain parts of the mind.

- **Ask yourself questions.** This is an effective way to not only gain insight, but to lessen the grip the bias has on you. Whenever a thought or bias arises, you can ask yourself: "Is this bias of mine fair, relevant or even worthy of having?" "Does this prejudice own me?" "Does this help anyone?" "Is this really a prejudice?" “How did I this prejudice, and why is it so powerful?" “Why do I find it important?". These questions can help you understand as well as let go of your biases.

- **Meet the object of your bias with an open mind.** The most effective (and hardest) way to get around it is to meet and face it. Accept that you have a bias against a certain religion or nationality. Be willing to research the religion or nationality in question by attending cultural events offered by embassies, and meeting people of that group.
Ultimately, take things a step at a time. It becomes easier the more you want to let go of the bias. The whole process of overcoming a bias is to understand what a bias is and how you got them, whether they are for your benefit and well-being or will make you cold-hearted and cruel. Finally, check your own feelings about linked to your biases regularly. Doing this can allow you to start to build practice and skills in letting go of the bias, and overcome it through investigation and attention.

- Therapists must be aware of how Black clients have been impacted by the MAAFA (African Holocaust), a great disaster of death and destruction beyond human comprehension and convention. Attempt to understand the denial of the humanity of African people and how the residuals from those experiences impact their lives.
  - Acquaint clients with the constructs of PTSD and ways in which the MAAFA may have impacted their lives. For example, six ways that the MAAFA still negatively impact African Americans today include:
    I. **Names.** Just as Kunta Kinte was forced under the lash to change his name in the novel and movie *Roots*, Black people both in the West and Africa were forced to take their slave masters’ last names. Today, many Black people carry European or Arabic names, which is a direct link to African American enslavement.
    II. **Food.** The diets of many Black people who in live in the Diaspora are a direct result of their diet in slavery. Slave masters generally consumed the lean and fleshy parts of farm animals, and left the scraps for the enslaved. Enslaved Africans were forced to incorporate those leftovers – such as
chitterlings, ox tails, tripe, pigs feet, cow foot, and other bad foods – into their daily meals. Those unhealthy foods are still part of the diets of many Black people today. They are harmful to the body, and cause chronic illnesses that plague our communities (strokes, high blood pressure, diabetes, heart disease, etc.).

III. **Economics.** Before Arab and Transatlantic Slave Trade, many African economies flourished, and were the foundation of stable, developed societies. Mansa Musa, who was king of the great Maliempire in the 14th century, was the richest man on the planet, worth $400 billion dollars, which is more than any Black nation’s annual GDP today. Blacks tend to invest the majority of their income in white communities to the detriment of their daily lives and well-being.

IV. **Language.** Currently the official language of many people who are African or African descent is either European or Arabic. Whether it was during the 8th century Arab invasion in north Africa or the European colonization and slave trade that began in the 15th century, foreign languages were forced upon Black people and have been the legacy for generations.

V. **Self hate.** The slave masters used Machiavellian systems to mentally break the enslaved Africans. While validating themselves as superior, they used every propaganda tool within their power to teach Black people to hate themselves. The results still have a major impact on the psyche of black people today.
VI. **Family.** A weakened Black family emerged from slavery. The destruction of the family unit through the slave master’s intrusive sexual exploitation of women and other evil designs, evolved into a volatile moral code for Black people. As a consequence, today over 70 percent of African-American children are born to unmarried women in America. That number is an astonishing residual effect of African slavery. Such large numbers children born to single mothers is clearly the wrong model for a stable, secure future for Black people, as there is a direct link between an absent father and an increased chance that a child will drop out of high school and have a criminal record.

- Therapists must be aware of his or her role as clinicians.
- Therapists must be aware of how people and elements in the universe are interconnected. African-Centered Psychology recognizes: *the spiritness* that permeates everything that is; the notion that everything in the universe *is interconnected*; the value that *the collective* is the most salient element of existence; and the idea that *self-knowledge* is the key to mental health. This refers to a Black Worldview, which is more holistic and integrative.
- Therapists must have a sense of his or her own essence and spirit in addition to being in touch with one’s spirituality.
- Therapists must have a sense of his or her own ethnic consciousness, which is not simply anchored in race (biology), but in the shared struggle and collective heritage of African American people.
- Therapists must be aware of how to move from possessing intellect to dispensing wisdom. This refers to having cultural sensitivity and understanding.
Knowledge

- Knowledge of African Psychology and African American history.
- Knowledge of the essential components of an African-Centered Worldview.
- Knowledge of limitations of traditional Euro-American psychological perspectives when applied to African-decent people
  - Knowledge of how science has been used as a tool of oppression
  - Knowledge of the limitations of traditional approaches to therapy.
- Knowledge of the characteristics and dynamics of personality development
- Knowledge of assessment instruments appropriate for use with African-descent adults, youth, and children. This refers to culture free psychometric instruments.
- Knowledge of the limitations of traditional assessment instruments when used with African Americans
- Knowledge of diagnostic nosologies used to classify disordered behaviors in African Americans.
- Knowledge of how traditional ethical standards of some psychological and counseling associations may be culturally inappropriate for African-decent people.
- Knowledge of geopolitical view of African people and their conditions in America and throughout the world
- Knowledge of what racism and White supremacy are, and how individual, institutional, and cultural racism impact the lives of African-decent people.
- Knowledge of communities, institutions, and resources that provide both tangible and intangible support to the African American community.
Knowledge of the dynamics of the African American family in the African American community.

Skills

- Ability to maximize congruence between healing messages and proper conduct.
- Ability to connect with, bond with, or otherwise establish rapport with African American clients.
- Ability to hear both the surface structure and deep structure messages clients communicate. This refers to understanding the clients' internal reality and experience.
- Ability to administer and interpret culturally appropriate assessment instruments.
- Ability to advocate on behalf of clients to social agencies and institutions.
- Ability to utilize theories and constructs in forming diagnostic impressions.
RESOURCE SECTION

Literary Resources

Historical Antecedents:


James G.G.M. (1976) *Stolen Legacy*. San Francisco: Julian Richardson Associates. Proffesor James suggests that what is currently known as Greek philosophy was, in fact, stolen from the ancient Africans.

Assessment and Appraisal


Hilliard, A.G III (1981) I.Q. As Catechism: Ethnic and cultural bias or invalid science.” Black Books Bulletin, 7 (2). A deconstructionist examination of ways and intelligence testing has been used to assert, maintain and justify racism.

Counseling/ Clinical Therapeutic Interventions


Spiritual Centers

There exists a wide variety of religious beliefs regarding health, illness, and healing among African Americans. Many spiritual churches arose in the early 20th century, and are characterized by their combination of elaborate rituals, highly aesthetic sanctuaries, intensely emotional services of worship, openness to women ministers; and eclectic belief system. Drawing on Roman Catholicism, Pentecostalism, 19th-century Spiritualism, New Thought, and African religious concepts that were incorporated into what is known as Voodoo or hoodoo in the United States, the spiritual churches have created ritual spaces where people can combine features of these religions in a variety of ways. A part of what attracted people to the Spiritual churches in the early days, and continues to do so now, is their reputation for healing and prophecy. Today's leaders of the spiritual churches are men and women who often are recognized as “prophets,” “divine healers,” or “spiritual advisors”.

The following leaders and spiritual centers serve as guidance on how African Americans often seek healing:

The Church of God in Christ

3045 Crenshaw Blvd, Los Angeles, CA 90016

Phone: (323) 733-8300

At: West Angeles Christian Academy

Website: westa.org

Bishop Charles Blake serves as presiding Bishop of the 6 million member Church of God in Christ (COGIC) denomination – one of the nation's largest denominations. He is also pastor of the 26,000-member West Angeles COGIC located in Los Angeles. In addition to his work as a
pastor, Blake also overseas a ministry which supports more than 350 orphanages through sub-Saharan Africa.

**Christian Cultural Center**

**Address:** 12020 Flatlands Ave, Brooklyn, NY 11207  
**Phone:** (718) 306-1000  
**Website:** cccinfo.org

In Brooklyn, the Rev. Bernard is senior Pastor of the 28,000-member Christian Cultural Center. His radio broadcast is heard by 300,000 listeners, and is influential in the political arena. He is sought often by presidents, senators, and politicians, and has been invited to join the board of the New York City Economic Development Corporation and the Board of the Directors of the Brooklyn Public Library.

**Trinity United Church of Christ**

**Address:** 400 W 95th St, Chicago, IL 60628  
**Phone:** (773) 962-5650  
**Website:** trinitychicago.org

The outspoken Rev. Jeremiah Wright, pastor of Trinity United Church of Christ in Chicago, is known for being unabashed when speaking about subjects such as AIDS in the African-American community. Wright is credited for introducing Sen. Barack Obama (D-Ill.) to Christ and the senator still seeks his guidance on spiritual matters.

Lastly, there is Archbishop Peter Akinola, who although is not an American, has played a major role in the schism within the U.S. Episcopal Church over the ordination of homosexuals.
Conservative Episcopal churches in America have voted to split from the Episcopal Church and asked Akinola to be their archbishop.

**The Nation of Islam**

7351 South Stony Island Ave  
Chicago, IL 60649

The Nation of Islam, abbreviated as NOI, is an African American political and religious movement, founded in Detroit, Michigan by Wallace D. Fard Muhammad on July 4, 1930. Its stated goals are to improve the spiritual, mental, social, and economic condition of African Americans in the United States and all of humanity. In 2007, the core membership was estimated to be between 20,000 and 50,000.

After Fard disappeared in June 1934, the Nation of Islam was led by Elijah Muhammad, who established places of worship (called Temples or Mosques), a school named Muhammad University of Islam, farms, and real estate holdings in the United States and abroad. The Nation has long been a strong advocate of African-American businesses.

There were a number of splits and splinter groups during Elijah Muhammad's leadership, most notably the departure of senior leader Malcolm X to become a Sunni Muslim. After Elijah Muhammad's death in 1975, his son, Warith Deen Mohammed, changed the name of the organization to "World Community of Islam in the West". In 1977, Louis Farrakhan rejected Warith Deen Mohammed's leadership and re-established the Nation of Islam on the original model. He took over the Nation of Islam's headquarters Temple, Mosque Maryam (Mosque #2) in Chicago, Illinois. Since 2010, under Farrakhan, members have been strongly encouraged to study Dianetics, and the Nation claims it has trained 1055 auditors.
Educational Video

*The Psychological Residuals of Slavery*

by Kenneth V. Hardy

A powerful exploration of the psychological legacy of slavery; an extremely useful educational resource for diversity and multicultural training.

As internationally acclaimed family therapist and educator, Kenneth V. Hardy observes in this compelling video, slavery remains a "contemporary ghost" that shapes African Americans' self-image, their relationships to one another and their relationships with White Americans.

Behind a backdrop of powerful historical and contemporary imagery, Hardy clearly demonstrates the importance of recognizing and openly addressing the past, and lays the groundwork for genuine dialogue, understanding, and healing in clinical environments, classrooms, and other settings.

This video is a catalyst for discussion; it is a tool for moving toward a more promising future by honestly confronting this deeply significant and painful aspect of our collective past.
Conclusion

African Americans and European Americans share many values and norms, as do individuals from many other cultures. However, there are particular factors that should be accounted for in working with many African American clients. You must also be aware that African Americans are a diverse group, and that individuals vary by social class, religion, region, education, and biculturality. It is important to remember that each client be seen as an individual with the following factors kept in mind.

- Spirituality and religion are highly important and integral for most African Americans.
- Family is often broadly defined as extended networks of family members and friends.
- Communication is often expressive, highly animated, and creative.
- Language is sometimes the dialect variously called African American Vernacular English or Black English, and is a means of bonding with other African Americans.
- Discrimination is a societal reality for many African Americans.

Remember, Worldviews and values may manifest themselves during sessions with African American clients. While many counseling methods used with European Americans apply to work with African Americans, all counselors should consider four key points.

Key points to consider during counseling practice include the following:

- Acknowledge societal bias, sometimes by introducing the issue and inquiring about the client’s understanding of prejudice.
- Include family and ancestors as sources of pride and support.
- Advocate for the client and the group by supporting and empowering the client. For example, encourage networking with supportive others and taking affirmative actions.
• And, if you are not African American, proactively build trust in intentional ways. For example, be genuine and broach the cultural differences in the room.