The common historical threads shared by African Americans present them with challenges not typically experienced by other groups. First, their unique history of slavery has left an ongoing legacy of racism and oppression (see Hollar, 2001, for a thorough historical review). Slavers actively attempted to eradicate African culture and break up family units for profit and convenience (Black, 1996). Since the end of slavery in 1870, racially hostile laws and practices have continued in such forms as the dehumanizing Jim Crow laws of the late 1800s, lynchings into the 1930s, and school segregation that did not become illegal until the Brown v. Board of Education Supreme Court decision in 1954 (Hollar, 2001). Moreover, from the early to mid-1900s, many African Americans migrated from the rural south to the urban north to escape this brutality and segregation and to find employment, which resulted in wide-scale disruption of their families and communities (Young, 2003). African Americans continue to experience discrimination in employment and housing (Coleman, 2003; Ross & Turner, 2005), exclusion and negative stereotyping by the media (e.g., Coltraine & Messineo, 2000), inferior health services (Hollar, 2001), and higher morbidity rates (Hines & Boyd-Franklin, 1996). Such assaults and challenges contribute to a poverty rate
that is higher than that of all other ethnic groups except Latinos (Dalaker, 2001) and mental health disparities between African Americans and other groups (e.g., U.S. Department of Health and Human Services, 2001).

COMMONALITIES RELEVANT TO TREATMENT

African Americans are very aware of racism and report significantly more chronic stress related to discrimination than do Whites (Schulz et al., 2002; Troxel, Matthews, Bromberger, & Sutton-Tyrrell, 2003). In one study, African American women reported experiencing racism an average of 75 times per year (Clark, 2000). Such experiences are also pervasive in mental health research and treatment, and many African Americans know that the field historically has held a pathological and deficit view of them (R. T. Jones, Brown, Davis, Jeffries, & Shenoy, 1998).

Across the life span, African Americans' reports of racism and discrimination are negatively associated with psychological and physical health and positively associated with substance use (Bowen-Reid & Harrell, 2002; Krieger & Sidney, 1996; Kwate, Valdimarsdottir, Guevarra, & Bovbjerg, 2003). In one study, racist events accounted for 15% of the total variance in psychological symptoms expressed by 520 African Americans (Klonoff, Landrine, & Ullman, 1999). The associations between perceived racism and psychological functioning are partially mediated through the effects of perceived racism on stress and self-esteem (DuBois, Burk-Braxton, Swenson, Tevedale, & Hardesty, 2002; Guthrie, Young, Williams, Boyd, & Kintner, 2002). In addition, the relationship between perceived racism and psychological functioning tends to remain even when demographics and stressors are controlled (Klonoff et al., 1999; Schulz et al., 2002). Although these associations are derived from correlations, such factors are relevant to treatment because anger at perceived racism and discrimination is one of the primary reasons that many African Americans seek therapy (Clark, 2000).

African Americans' experiences of inequity and stress adversely affect their psychological adjustment and can lead to particular symptom presentations. For example, many African Americans experience rage that may be expressed toward White therapists or therapists of color who are seen as representatives of the dominant culture. Anger may also be directed toward family members because they are safer targets, or because family members fail to support one another, for example, arguing over who experiences the worst racism or how racist incidents should be handled (e.g., Boyd-Franklin & Franklin, 1998; Kelly, 2003). Many African Americans feel a deep distrust of Whites rooted in generations of negative experiences. Often referred to as a "healthy cultural paranoia," this distrust is associated with an unwillingness to seek mental health services, negative attitudes toward White therapists, and premature termination rates (Whaley, 2001).
African Americans also may present with worldviews related to the pain of oppression. For example, some may exhibit internalized racism as manifested in negative in-group statements and a preference for White therapists whom some may perceive as more competent than African American therapists (Boyd-Franklin, 2003; Hardy, 2004; Kelly, 2003, 2004). Some African Americans become demoralized by racism, leading to feelings of nihilism, an external locus of control, or a fatalistic perspective (e.g., Hines, 1998). It is easy for therapists to misinterpret these worldviews and related coping responses as blaming others, self-pitying, or lacking motivation. Laszloffy and Hardy (2000) described such an example in the following summary.

In the first session between a therapist and an 11-year-old African American boy diagnosed with conduct disorder, the child described his misbehavior as related to his dislike of his teacher, who he felt was racist. After hearing his examples, the therapist, who was White, told him that he may have misunderstood the teacher’s intentions and actions and that his anger was no excuse to break the rules. Moreover, the predominantly White supervisory team behind the two-way mirror agreed with the therapist; they all viewed the boy’s behavior through the lens of his disorder, and none considered race or racism in their discussion. Not surprisingly, the child and his family discontinued treatment.

Several common cultural tendencies among African Americans may present challenges to traditional psychotherapy. A focus on the present can result in a lack of planning for a future that seems uncertain owing to racism (Hardy, 2004). Beliefs that “the future will wait” and experiences with social services that require people to wait for hours may foster excessive lateness and missed appointments (Hardy, 2004). In valuing direct experience in deciding whom to trust, African Americans may ignore a therapist’s academic degrees and suggestions until they are sure of the feeling or “vibes” they get from the therapist (Boyd-Franklin, 1998). Despite therapists’ training against corporal punishment, data from large samples show that it is not associated with negative outcomes in African American communities in which it is prevalent (Simons et al., 2002) and in which the children do not view it as a sign of caregiver rejection (Rohner, Bourque, & Elordi, 1996). Finally, therapists may misinterpret emotional expressiveness, nonverbal communication, and nonstandard language as an inability to regulate emotions and communicate effectively (e.g., Boyd-Franklin, 2003; Kelly & Boyd-Franklin, 2004).

Cultural Strengths

Cultural strengths and supports among African Americans can help to offset the adverse effects of racism and discrimination. The extended family is an important source of strength and support originating in African cultures that can include blood kin such as cousins and “fictive kin” who are unrelated by blood (e.g., members of a “church family” or a “play mama”;

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Boyd-Franklin, 2003). The extended family may engage in reciprocal assistance with money, goods, and services that increase the economic viability of African American families (Taylor, Chatters, & Jackson, 1997). Extended family members may share their homes with each other for short-term stays during times of financial hardship or longer periods, as in the case of informal adoption (e.g., Boyd-Franklin, 2003). Extended family members may also serve as mediators, judges, or networkers, flexibly adopting these roles as needed. African American parents also prepare their children for the race-related struggles they will encounter (Fischer & Shaw, 1999). Overall, surveys show that proximity, subjective closeness, and frequency of kinship interaction contribute to the physical and emotional well-being of African Americans (Taylor et al., 1997).

Religious institutions and spiritual beliefs are additional sources of strength for African Americans, and data have consistently demonstrated greater levels of religiosity and spirituality within African Americans as compared with other ethnic groups (e.g., Taylor, Mattis, & Chatters, 1999). African American churches provide formal and informal supports such as childcare and educational programs that help to improve the welfare of African Americans (Ellison, 1997). Churches enable African Americans to achieve status in their communities, for example, through leadership roles that compensate for the lack of occupational and educational opportunities and status in the dominant culture (Boyd-Franklin, 2003). Churches also encourage and support the development of organizational skills and social activism (Taylor et al., 1999). For many African Americans, religion and meaning-enhancing attributions regarding God are significantly associated with individual and family well-being (Blaine & Crocker, 1995; Ellison, 1997).

A positive racial or ethnic identity is another source of strength for African Americans. Multicultural research shows that a positive ethnic identity is associated with increases in self-esteem, coping, mastery, and optimism, and with lower levels of loneliness, anxiety, and depression (Carter, Sbrocco, Lewis, & Friedman, 2001; Phinney, Cantu, & Kurtz, 1997; Roberts et al., 1999). In addition, for African Americans, a positive ethnic identity acts as a buffer against perceived discrimination and racism (Wong, Eccles, & Sameroff, 2003).

Individual Differences

Many demographic factors including but not limited to skin color, gender, and socioeconomic status profoundly affect the experiences of African Americans (Celious & Oyserman, 2001). Data show that socioeconomic gaps between light and dark African Americans are of the same magnitude as the gap between Whites and Blacks in the United States. Those who are light may be considered prettier, are more affluent, and receive better treatment in society. Still, both very light and very dark African Americans can expe-
rience bias. For example, those who are dark are sometimes prized within the community because they are considered to be racially pure (Celious & Oyserman, 2001). Societal stereotypes of African American men elicit fear and hostility (e.g., violent criminals), whereas those of African American women elicit derision and sexual intrigue (e.g., welfare queens and “Jezebels”). Such treatment results in differing experiences for each gender (Celious & Oyserman, 2001). African Americans’ socioeconomic status is positively associated with their perceptions of discrimination, perhaps because the economically privileged have greater contact with the larger society that discriminates against them (Cutrona et al., 2003). Conversely, poorer African Americans are less likely to benefit from government programs that tend to go to their brethren of higher socioeconomic status, perhaps because many in the larger society assume that all African Americans are poor (Celious & Oyserman, 2001). Given these and other differences, it is important to note that there is no single “African American experience” (Black, 1996).

Although the primary focus of this chapter is on African Americans, differences between African Americans and immigrants from the African diaspora deserve mention (for further reviews, see McGoldrick, Giordano, & Pearce, 1996; Stephenson, 2004). Unlike African Americans, many Black immigrants have not experienced American slavery and racism or the loss of many cultural connections. Many Black immigrants (e.g., West Indians and Africans) are the majority group in their country, so they may define race more broadly than African Americans, and they often do not experience it as an indicator of success or social mobility. Often, these groups immigrate voluntarily to partake in the American dream, and many have the option of maintaining ties with home or of returning home (Stephenson, 2004). Finally, whereas all Blacks share an African cultural legacy, Black immigrants also have unique cultures related to their country and its history of colonization. For example, many Caribbean Blacks are influenced by British culture, and South American Blacks are influenced by Spanish culture (Black, 1996).

Initially, these differences often result in less awareness of racism, a greater belief in meritocracy, more positive feelings about White Americans, and more varied notions of identity as compared with African Americans (Phinney & Onwughalu, 1996; Stephenson, 2004). Thus, when confronted with racism, some Black immigrants may experience shock, may distance themselves from African Americans because of their differing national identities, or may circumvent the adoption of what they view as a restrictive, inferior status (Stephenson, 2004). Still, data show that American-born children of Black immigrants, and the immigrants who stay in the United States for long periods, often develop racial identities and stances that are more similar to those of African Americans (Phinney & Onwughalu, 1996; Stephenson, 2004).

Often, African Americans with the same backgrounds may behave in radically different ways owing to their different levels of acculturation and
different racial identities. Acculturation refers to the extent of adoption of the dominant culture versus one's indigenous culture (Klonoff & Landrine, 2000). Studies show that African Americans' level of acculturation is associated with how they cope with stress, their level of social support, psychological symptoms, and health-related behaviors (Klonoff & Landrine, 2000). Acculturation also can produce stress that affects psychological functioning beyond the effects of general life stress (Joiner & Walker, 2002). In treatment, knowledge of acculturation can indicate the likelihood that a given African American client might present in ways more common to African Americans or ways more common to White clients. Overall, acculturation levels often account for much more variance in African Americans' behavior than do education and income combined (Klonoff & Landrine, 2000).

Jim, a White male, had his first session with Larry, an African American male in his early 20s, who was born and raised in Los Angeles, California. In his attempt to develop rapport with Larry, Jim mentioned how the West Coast was really cool because West Coast rappers made the best hip-hop music. To Jim's surprise, Larry said, "I have no idea what you are talking about. I play the cello and study classical music." Jim told his supervisor, who gave him readings on acculturation theory and other aspects of diversity among African Americans, which they then discussed. Thereafter, Jim learned to ask questions aimed at obtaining a better understanding of his clients' levels of acculturation.

Similar to acculturation, consideration of racial identity is important in treatment, as it also involves one's orientation toward one's own group and toward the dominant group (for a review, see Vandiver, Cross, Worrell, & Fhagen-Smith, 2002). Clinical observations indicate that therapists of color who see African American clients may receive questions as to their competence, responses conveying distance and dissimilarity, or responses conveying feelings of similarity and connection (Boyd-Franklin, 2003). White therapists commonly encounter reluctance to receive treatment, anger related to oppression, or an ingratiating, deferential style (Boyd-Franklin, 2003). Racial identity can explain these observations; data show that racial identity predicts the degree of preference for African American versus other therapists (e.g., Goodstein & Ponterotto, 1997).

ADVANTAGES OF COGNITIVE-BEHAVIORAL THERAPY

With its emphasis on tailoring therapy to the particular individual, CBT has the potential to positively address African Americans' treatment needs. Assessment data are gathered from multiple sources, such as interviews and questionnaires, and are used in a functional-analytic approach that recognizes the diversity of environmental influences and paths to symptom reduc-
tion (Jacobsen & Christensen, 1996). A CBT approach can help therapists to avoid a judgmental stance toward differences and help clients to do the same (Jacobsen & Christensen, 1996). For example, as radical Black behaviorism states, observable behavior should never be explained by unobservable mentalistic events such as motivation or intelligence but rather understood in light of its environmental consequences (Fudge, 1996).

A second advantage of CBT with African Americans is the collaborative nature of the treatment; the therapist is the expert on the treatment, but clients are the experts on themselves and their problems (e.g., Briesmeister & Schaefer, 1998). For example, in cognitive-behavioral parent training, therapists provide parents with the skills to become effective cotherapists in facilitating change with their children. The therapist and parents share their expertise to benefit the child and family. Parent training is problem focused, with everyone working together on problems defined by the parents. Parents also have control over the duration of treatment, as it ends when the parents report that their child's symptoms are no longer a problem. Similarly, therapists conducting behavioral couple therapy seek to establish a collaborative set using data to develop shared conceptualizations, rationales by which behavioral principles can help, and encouragement of mutuality in goal setting and choice of intervention. Therapists assist partners in taking a hypothesis-testing stance toward resolving their issues (Sayers & Heyman, 2003). This emphasis on a collaborative set was speculated to be the reason that observers in one study rated CBT significantly higher on the therapeutic alliance than psychodynamic treatments (Raue, Goldfried, & Barkham, 1997).

A third potentially beneficial characteristic of CBT with African Americans is its emphasis on empowerment. CBT empowers African American clients by helping them to build strengths, supports, and skills to meet their goals more effectively (Sayers & Heyman, 2003). Therapists actively help clients look for ways to build on and expand social support, and to recognize coping skills that have worked for them in the past and may work again (Epstein & Baucom, 2002). Clients are also taught to look for and expect evidence of ongoing improvement and to use behavioral experiments that provide evidence to replace their cognitive distortions with realistic, noncatastrophic appraisals (e.g., Briesmeister & Schaefer, 1998).

In summary, the advantages of CBT with African Americans include an emphasis on nonjudgmental, collaborative problem solving and empowerment of the client through skill building and strengthening of natural support systems. These key components are illustrated in this example:

Peter was an African American first-generation college freshman who sought treatment at the university clinic for depression and difficulties completing schoolwork. His therapist was John, a White, third-generation Italian American. As Peter was attending college locally, part of his problem involved the racial differences between his college peers and him,
and the pressure he felt from his high school friends who had not “made it” to college. His friends gave him messages to “keep it real and stop acting like those preppy White boys.” John avoided the assumption that Peter’s friends were bad. Nor did he try to break Peter’s friendships by encouraging him to behave more like his White peers in college. Instead, John encouraged Peter to talk about his friendships and normalized his experiences by suggesting that it is not an uncommon coping mechanism for friends to denigrate experiences that they have not had together, as a way of preventing the loss of the friendship. Following John’s normalizing, psychoeducational reframe, Peter described several times when his high school peers had applauded his academic efforts. They then began to problem-solve how to maintain his old friendships as a means of improving his depression and academic performance.

LIMITATIONS OF COGNITIVE-BEHAVIORAL THERAPY

A major criticism of CBT addresses the claim by many cognitive-behavioral therapists and researchers that the approach is neutral and universally applicable owing to its scientific orientation. Sue (1999) challenged this myth by noting researchers’ and therapists’ selective enforcement of the scientific principles of skepticism and convinciness, for example, the lack of skepticism regarding the generalizability of findings for White Americans to ethnic minority groups. Conversely, some claim that findings obtained from ethnic minorities are not generalizable if they lack a White control group. Another bias is the assumption that one must take a “colorblind” approach to ensure the fair treatment of ethnic minorities, an assumption that works against the consideration of cultural influences on human behavior (Iwamasa, 1997).

Fudge (1996) noted that science continues to sanction the use of many nonscientific concepts to explain African Americans’ behavior. For example, subjective assertions of negative innate or genetic tendencies have long been made regarding African Americans, and even today deficit models regarding African Americans’ differences from Whites are readily believed and investigated. For example,

Sheila, an African American student, began treatment at a local counseling center because of the stress of her first year of graduate school in biology. In an early session describing her feelings of alienation on campus, she complained to her therapist that one of her professors described research investigating genetic causes of Black violence, as if African Americans were inferior and genetically prone to violence. Although her White female therapist empathized with her, being a cognitive-behavioral scientist-practitioner, the therapist tried to explain the teacher’s perspective by saying, “It may help you to know that in the pursuit of knowledge, scientists should be able to study any topic.”
student was offended and angrily quipped, “Well, I never heard about studies of a gene for violence in Whites back when they were lynching and conquering everybody.”

Beyond the therapist's discounting of her client's experience of oppression, this vignette highlights the Eurocentrism embedded in CBT and in the research base on which it is founded. African Americans are underrepresented as research participants and as researchers (Baucom, Shoham, Mueser, Daiuto, & Stickle, 1998), and as such exert little influence on the topics, direction, and value placed on areas of psychotherapy research. The psychotherapy research that does exist regarding African Americans is still at the descriptive and understanding phases, far behind the prediction and control phases of research regarding White Americans. This lag perpetuates the circular reasoning that cultural adaptations of CBT are not needed because no evidence exists regarding its cross-cultural effectiveness.

Eurocentrism is also a problem in some applications of cognitive-behavioral theory. For example, the emphasis on rational thinking can be interpreted in ways that devalue African Americans' spirituality and tendencies toward emotional expressiveness. One African American client reported that her depression would increase if she could not cry and let out her emotions periodically. This sounded illogical and too much like catharsis for her therapist, who challenged her belief and tried to help the client to see the value in regulating her emotions. The client then felt chastised and began to try to hold in her tears, even though they functioned as a stress reliever in her life.

Similarly, mainstream values regarding the importance of personal independence and autonomy tend to be reinforced by cognitive-behavioral orientations. Cognitive-behavioral therapists who fail to recognize the importance of family and community for their African American clients may be seen as reinforcing dominant cultural values. At the same time, they may overlook important sources of familial and community support that could be incorporated into cognitive-behavioral interventions. This individualistic focus also may inhibit therapists from addressing factors in the larger African American community that are relevant to African American clients.

African American therapists have noted additional reasons why attention to the larger African American community is important in the treatment of African American clients, beyond its usefulness as a source of strength and support (e.g., Fudge, 1996; McNair, 1996). First, the ability of African Americans to effect positive change in their communities can be empowering. Second, the notion of working for or healing the community is consistent with an African-centered perspective that encourages responsibility and self-determination. Third, the promotion of positive external change can help to heal painful feelings and perceptions related to a negative ethnic identity. Fourth, from a behavioral perspective, involvement in the commu-
nity can help African Americans to actively change the contingencies in their environment that maintain their current symptoms of distress (Fudge, 1996; McNair, 1996). Finally, at times, larger social issues are directly relevant to African Americans' presenting problems. For example, African American men often hold anxiety related to their abilities as providers that negatively affects both their couple and family functioning (Kelly, 2003; Kiecolt & Fossett, 1995).

In summary, it is only fair to note that many of the preceding criticisms pertain less to the theory of CBT than to those who practice it without cross-cultural knowledge and awareness. Moreover, being a therapist of color is no guarantee against cultural biases, as therapists of color receive the same training as White American therapists, and treatments in the United States are often exported internationally (Iwamasa, 1996). Although there is no substantial literature on culturally adapted CBT with African Americans, the results of a recent nonrandomized study are promising. Kohn, Oden, Munoz, Robinson, and Leavitt (2002) found that the Beck Depression Inventory scores of depressed, low-income African American women who received culturally adapted group CBT decreased twice as much as those of their counterparts who received traditional CBT.

MODIFYING COGNITIVE-BEHAVIORAL THERAPY FOR AFRICAN AMERICANS

Given the Eurocentric biases embedded in cognitive–behavioral research and theory, along with therapists' documented diagnostic and treatment biases regarding African Americans (e.g., Atkinson et al., 1996), the first essential modification of CBT involves therapists' self-exploration and education. This includes exploration of one's own racial and cultural identity, as well as education regarding institutional and structural aspects of racism including the concepts of White privilege and power (McIntosh, 1998). Therapists should gain knowledge of and exposure to African Americans and immigrants of African descent in real-world settings in which the therapist is not in a dominant role, such as that of a teacher or therapist. Supervision and case consultation are also important, particularly when therapists lack knowledge of culturally acceptable and normative behaviors and beliefs (e.g., Kelly, 2003).

Regarding modifications of CBT, it is useful to return to the preceding cases wherein therapists, in their attempts to be helpful, gave their clients benign interpretations of the clients' reported racist experiences. When therapists dismiss clients' beliefs about the presence of racism, they prevent themselves from conducting a complete functional analysis of the client's behavior. Furthermore, they decrease clients' willingness to further disclose how racism is related to their problems. Even in optimal conditions, African American clients may be reluctant to consider how racism may be related to
their symptoms. Thus, one of the most important actions a therapist can take is to begin with the supposition that the racist incident occurred and assess how it is relevant to the problem.

The next key action is to validate the client's experience of racism and discrimination (Lasloffy & Hardy, 2000; McNair, 1996). An example is provided by Fink, Turner, and Beidel (1996), which I summarize here:

A 39-year-old African American female physician was diagnosed with social phobia based on her description of her fear of speaking in front of her colleagues, and the belief that they would view her as stupid and not cut out to be a physician. In an intervention using imaginal exposure, early exposure sessions did not produce the expected arousal levels, indicating that the presented cues were not salient in invoking her symptoms. However, further exploration revealed that she was the only African American resident at her job, and that her symptoms were elicited in situations primarily involving middle-aged White male colleagues. In particular, she reported believing that these colleagues viewed her as incompetent and undeserving of being a physician largely because of her race, and that they thought she was admitted to medical school only because she was African American. Fink et al. (1996) noted that "racially relevant cues enhanced the social-evaluative, fear-producing quality of the scene as reflected by the patient's verbal report, behavior, and an index of arousal" (p. 208). Subsequently, racial cues were used systematically in her in vivo homework exercises, resulting in the extinction of her core fear, which was racially based.

Once a therapist recognizes the reality of racism in African Americans' lives, he or she will be better prepared to join with African American clients to form a collaborative therapeutic alliance. This joining must occur early in treatment if it is to prevent dropout, which is significantly higher among African Americans than among Whites (Fudge, 1996). Therapists are encouraged to give every indication of respect to African Americans via supportive and noncritical statements, a lack of jargon, and asking clients whether they prefer to be addressed by first or last name (Wright, 2001). Nonthreatening psychoeducation regarding the purposes, course, and process of therapy, along with clear expectations regarding therapist and client roles, can help to increase the therapeutic alliance. Also important is the avoidance of affiliation with agencies that have a negative reputation in the community.

Therapists must gain the courage to raise the topic of race and ethnicity in a way that is comfortable for them and communicates to the client that anything can be discussed (Hines & Boyd-Franklin, 1996). In some cases, the therapist may choose to identify his or her own racial, ethnic, and cultural background, and then ask the client to do the same. In other situations, open-ended questions may be more appropriate, for example, "Are there aspects of your race or culture that you think are important for me to know about in working with you?" Questions regarding specific cultural influences
may also be helpful, for example, “Do you have any spiritual or religious beliefs that are important to tell me about?” Questionnaires aimed at assessing racial identity, level of acculturation, or Afrocentricity can provide information regarding individual differences and the extent to which the client participates in his or her own ethnic traditions and in those of the larger American culture (e.g., Vandiver et al., 2002). When working with couples and families, the therapist should make such assessments for each individual, noting similarities and differences between family members.

In reference to the lack of empirical clarity regarding how race and culture affect treatment, Sue and Zane (1987) hypothesized two essential conditions for effective cross-cultural counseling. The first of these is therapist credibility, which refers to the client's beliefs that the therapist is capable of helping. The second condition involves giving and refers to the client's sense that the therapist has offered something valuable, such as a shift in perspective or a new solution to the problem. On one hand, therapists who do not acknowledge these factors will be at a disadvantage in understanding the function of their behavior for the client. They may also miss opportunities to allay fears related to cultural distrust and to address negative or irrational beliefs that the client may hold regarding the therapist. On the other hand, attention to the importance of credibility and giving for African American clients can significantly facilitate the therapeutic process.

A good friend recommended that Judy, an African American, seek treatment from Carol, a White therapist. In the first session, Judy was initially nervous but admitted to Carol that much of her problem stemmed from the racism and disrespect that she experienced at her job. She stated that she had begun to doubt her abilities. Carol told Judy how sorry she was that Judy was victimized by racism and made genuine statements affirming Judy's worth. During treatment, Carol conducted self-management and self-advocacy training with Judy to enhance her effectiveness in managing and connecting with her coworkers. Notably, Carol did not imply deficiencies in Judy, nor did she ignore or excuse any racism. Carol also helped Judy to challenge her self-doubts via positive statements about her race and culture. In hearing that Judy coped with the situation by working long hours and praying, Carol's interventions included asking Judy to put the work that she could not get done in the “something for God to do” box and pray on it. By the end of treatment, Judy reported a decrease in her feelings of stress and depression and stated that her relationships with the people that she managed were “much better.”

COGNITIVE-BEHAVIORAL THERAPY WITH AFRICAN AMERICAN FAMILIES

Jacobson and Christensen (1996) noted that couples composed of partners of different racial or cultural backgrounds may not recognize when their
conflicts stem from differing cultural norms, and that these conflicts can be exacerbated during times of stress. They asserted that CBT can be helpful with couples through attention to the environmental (i.e., cultural) influences on the couple. Conflicts can be reframed as at least partially related to larger social stressors affecting the couple, and to the ways in which each partner’s views have been shaped by their own cultural heritage (Jacobson & Christensen, 1996). This attention to larger, external influences can help to decrease defensiveness and increase understanding, thus facilitating collaborative problem solving.

Even when family members are both African American, such conflicts can easily arise as a result of individual differences in how each perceives and copes with racism and other social stressors (e.g., Kelly, 2003; Kelly & Boyd-Franklin, 2004). Boyd-Franklin and Franklin (1998) suggested use of the reframe that clients are “letting racism win” instead of uniting together to fight against it.

Kim and Terrance were an African American couple who sought therapy because of their frequent fights involving finances. Kim reported that Terrance did not bring her flowers, as some of her White coworkers’ partners did at their workplace. Terrance angrily replied that Kim was “always wanting something and testing my manhood.” The therapist, Sheila, tried a communication intervention that met with limited success in reducing the couple’s blaming of one another. Although she commonly used reframing to normalize stress for couples who were new parents, Sheila did not normalize the socioeconomic stressors of this couple. Neither did the couple think about their periodic unemployment as a chronic socioeconomic stressor.

In this case, the therapist might have been more effective if she had reframed the problem as described earlier. She could have observed that Kim and Terrance were letting racism win by turning their frustration regarding limited economic opportunities on each other. Furthermore, she could have encouraged them to work together and support each other toward coping and thriving in the face of discrimination and unfair treatment.

The idea of working together and supporting one another fits well with CBT’s emphasis on building strengths and supports. Toward this end, therapists may respectfully ask African Americans to share aspects of their heritage and background of which they are proud, and then acknowledge and validate those strengths (McGoldrick et al., 1996; Wright, 2001). It is also important to elicit information regarding strengths and supports that may have been disrupted over time but can be reinstated or rebuilt, for example, reconnecting with a “church family” or relatives.

Even when both partners are African American, therapists should assume that cultural similarities and differences may exist and thus encourage

(a) a conscious awareness by both partners of the role that culture plays in relationships; (b) the ability of both partners to experience ethnic and
cultural energies as an expansion rather than a threat to the self; and (c) the paradoxical ability of both partners to develop their own uniqueness because of the other partner's different cultural background. (A. C. Jones & Chao, 1997, pp. 169–170)

As part of these tasks, therapists should help clients to develop shared meanings, rituals, and spiritual understandings that transcend their cultural differences (A. C. Jones & Chao, 1997).

Incorporating clients' natural support systems may involve the inclusion of elders or other respected family members and clergy to collaborate in treatment (Boyd-Franklin, 1998). For some clients, forming an alliance with the person's pastor or religious leader can enhance treatment outcomes and provide additional therapeutic leverage. Therapists need to be aware of the supports offered by local African American churches and mosques, including couple and family ministries. Home visits, outreach to community organizations, and the identification of community role models can be helpful in developing realistic goals and supporting positive change. For African Americans who are not involved in organized religion, therapists should ask about the role of spirituality in their lives, and if this is significant, build on these beliefs as part of the therapy (Boyd-Franklin, 1998).

Research indicates that a negative racial identity is strongly associated with greater personal distress (e.g., Kelly, 2004). Given the chronic influences of racism and socioeconomic stressors in many African Americans' lives, therapists need to assess the degree to which their African American clients internalize racist and self-blaming societal messages. At times, clients may spontaneously express negative internalized stereotypes, as in the aforementioned case in which Terrance stated that Kim was testing his manhood. Unfortunately, the therapist did not recognize this statement as a common negative stereotype that depicts African American women as psychologically castrating of African American men.

In the case example of an African American man being treated for substance abuse, Fudge (1996) identified several key themes that revealed the client's negative racial identity. These included "Being Black means I'll never be good enough" and "Being Black means acting in a particular [negative] way" (p. 328). To counter such myths, the therapist used standard rational emotive therapy (RET) to help the client develop more realistic and positive self-statements. In addition, the therapist provided the client with culturally relevant readings, including The Autobiography of Malcolm X (1966) and Gordon Parks's autobiography, A Choice of Weapons (1965/1986), that were integrated into RET as bibliotherapy. These materials provided examples to which the client could relate, demonstrated African American men's transition from a negative to a positive racial identity, and helped the client to shift his own racial identity to a more positive direction. The therapist also empowered the client by encouraging him to take action on larger social
factors that he felt were related to his problem. This work involved problem solving, coaching, and role-playing, and eventually resulted in the client talking with the teens who drank and disturbed the residents in his building to decrease their noise level (Fudge, 1996).

CONCLUSION

CBT’s theory, philosophy, and use of idiographic data make it supportive of and suitable for use with African Americans. However, CBT is often conducted within mainstream America, which endorses a Eurocentric framework that is oppressive and damaging to African Americans. As a result, CBT has been tainted by myths of neutrality and universality that promote White privilege and justify the failure to include African Americans in clinical research. A burgeoning literature has begun to demonstrate the need for therapists to gain knowledge about and experience with African Americans. By calling attention to the unique experiences and strengths of African Americans, this training can help to counter therapists’ personal biases and the systemic biases within the field of CBT. Additional clinical research is needed to understand the ways in which racial and ethnic constructs are influential in the treatment of African Americans and how such factors are associated with outcomes.

REFERENCES


