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COUNSELING PERSONS OF BLACK AFRICAN ANCESTRY[1]

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Primary Objective

- To teach counselors how to identify and make reasonable accommodations for the unique psychological traits and sociocultural background of persons of Black African ancestry

Secondary Objectives

- To describe psychological, cultural, and sociopolitical issues that counselors might consider before working with clients of Black African ancestry
- To propose enhanced techniques and strategies for providing effective counseling services to African Americans and other clients of African descent

The purpose of this chapter is to help counselors explore practices and procedures that appreciate the culture, nomenclature, history, and clinical preferences of clients and counselor trainees of Black African ancestry. The chapter emphasizes ways in which counselors can enhance the quality and integrity of their services by developing a better understanding of (1) specific cultural norms and folkways, (2) how sociocultural power differentials manifest within a therapeutic context, and (3) how Black/African psychology tenets can shape clinical practice.

In many counseling settings, routine practices and compliance standards often diminish the quality of care for Black clients. Some counselors report that they often alter standards and bend rules, not only to enhance Black clients' services but also to protect them from maltreatment (Williams, 2005). For example, one Black counselor reported that he instructs his Black adolescent clients to use the title of "Brother" instead of "Mr." when addressing him. Another counselor described the dissonance she felt when she frankly told her client to "just ignore that label . . . that's not who you really are," when referring to her client's treatment plan diagnosis. Yet another counselor encouraged her client to call out the name of a deceased loved one to keep his memory alive

and not merely to "let go" of the past. Finally, a counselor admitted that he applauded his client's tough confrontation of her son's drug use. When used in traditional counseling settings, all of the above interventions may appear refractory and audacious, yet a body of literature supports their legitimacy for Black clients (Ayonrinde, 2003; Bhugra & Bhui, 1999; Brody et al., 2006; Harvey & Coleman, 1997; Herrick, 2006; Leavitt, 2003; Reiser, 2003; Toldson & Toldson, 1999; Wills et al., 2007).

Notably, nothing heretofore stated should be casually considered a counseling strategy for African Americans or any other client of Black African ancestry. Throughout this chapter, the authors will resist the impulse to directly suggest counseling strategies and hope that readers will not intuit counseling methods that they will "try out" on a Black client. The literature is replete with novel techniques to address the unique counseling needs of persons of African descent—too many to reiterate in this chapter but no less deserving of consideration.

However, counseling strategies are not the primary problem when working with Black clients. No counseling strategy offers a recipe for healing all persons of African descent. Several articles have warned against using a "cookie cutter" approach to working with Black clients (Bowie, Cherry, & Wooding, 2005; Estrada, 2005; Respress & Lutfi, 2006; Taylor-Richardson, Heflinger, & Brown, 2006). Helpers must be self-aware and able to use themselves as agents of change (Sheely & Bratton, 2010). Moreover, the millions of Black people who exist are more different from one another than they are collectively different from other races (Jackson et al., 2004). In fact, the practice of force fitting Black people into a category reflects a Eurocentric paradigm that relies heavily on taxonomies to understand complex material (Leong & Wong, 2003).

Afrocentric approaches de-emphasize classification systems and guidelines and highlight relativity and rhythm (Cokley, 2005; Washington, Johnson, Jones, & Langs, 2007). In this view, counseling strategies are not rules that match a specific taxonomy of clients and their problems. Rather, the relative importance of a counselor's strategy depends on the rhythm and context of a session. The purpose of this chapter is to help counselors use their strategies within a context that appreciates Black people's common folkways and collective struggle. In North America and abroad, persons of Black African ancestry share common folkways that evince their African origin, cultural adaptations to colonial autocracies (e.g., language and religion), and a collective struggle against racism and discrimination.

History and Nomenclature

Persons of Black African ancestry live as citizens, foreign nationals, and indigenous populations on every continent as a result of immigration, colonialism, and slave trading. With an estimated population of 38.9 million, 12.6% of the total population of the United States, African Americans constitute the second largest non-White ethnic group in the country (Ruggles et al., 2009). According to the American Community Survey, in the United States, 80% of Black males and 83% of Black females age 25 and older have completed high school or obtained a GED. Forty-five% of Black males and 53% of Black females have attempted college, and 16% of Black males and 19% of Black females have completed college (Ruggles et al., 2009).

Today, most Black people in the Americas are the progeny of victims of the transatlantic slave trade. From 1619 to 1863, millions of Africans were involuntarily relocated from various regions of West Africa to newly established European colonies in the Americas.

Many different African ethnic groups, including the Congo, Yoruba, Wolof, and Ibo, were victims of the transatlantic slave trade. The Black American population is the aggregate of these groups, consolidated into one race, bound by a common struggle against racial oppression, and distinguished by cultural dualism (Toldson, 1999).

Importantly, the historic legacy of Black people in the Western Hemisphere is not limited to slavery. The Olmec heads found along the Mexican Gulf Coast is evidence of African colonies in the Americas centuries before Columbus arrived in the Caribbean (Van Sertima, 2003). Black people were also responsible for establishing the world's first free Black republic, and only the second independent nation in the Western Hemisphere, with the Haitian Revolution (Geggus, 2001). In the United States, almost 500,000 African Americans were free prior to the Civil War and were immensely instrumental in shaping U.S. policy throughout abolition and beyond. Post-Civil War, African Americans influenced U.S. arts, agriculture, foods, textile industry, and language and invented technological necessities such as the traffic light and elevators as well as parts necessary to build the automobile and personal computer. All of these contributions were necessary for the United States to become a world power by the 20th century.

Racism and oppression are forces that have shaped the experiences and development of Black people worldwide. Although European colonialists initially enslaved Black people because of their agricultural expertise and genetic resistance to diseases, they used racist propaganda to justify their inhumane practices (Loewen, 1996). During periods of slavery and the "Scramble for Africa," European institutions used pseudoscience and religion (e.g., the Hamitic myth) to dehumanize Black people. The vestiges of racism and oppression survived centuries after propaganda campaigns ended and influence all human interactions, including counseling relationships.

Today, racism is perpetuated most profoundly through the educational system. Loewen (1996) pointed out that students are taught to revere Columbus, who nearly committed genocide against the native population of the Dominican Republic, and Woodrow Wilson, who openly praised the Ku Klux Klan. Although many of these facts are not well known and purposefully disguised in history texts, children often leave traditional elementary and secondary education with the sense that aside from a few isolated figures (e.g., Martin Luther King and Harriet Tubman), Black people had a relatively small role in the development of modern nations (May, Willis, & Loewen, 2003).

Contemporary literature on the health and economic status of Black people, especially in the United States, is dismal. Evidence is often presented indicating that African Americans have the highest incidence of any given mental or physical disorder, are more deeply impacted by social ills, and generally have the lowest economic standing. While most of the statistics are accurately presented, rationales are usually baseless and findings typically lack a sociohistorical context. In addition, studies on African Americans unfairly draw social comparisons to the social groups that historically benefited from their oppression.

Historical distortions accompanying dismal statistics have resulted in many counselors perpetually using a deficit model when working with Black clients (Jamison, 2009). The deficit model focuses on clients' problems, without exploring sociohistorical factors or institutional procedures. Persons of Black African ancestry have a distinguished history, are immeasurably resilient, and have developed sophisticated coping mechanisms throughout centuries of

oppression. Appreciating and celebrating a client's legacy, contextualizing problems, and building on strengths instead of focusing on deficits are universally appreciated counseling strategies that merit greater attention when working with Black clients (Amatea, Smith-Adcock, & Villares, 2006).

Barriers to Cross-Cultural Counseling With Persons of Black African Ancestry

Before a person, particularly those who are not familiar with Black culture, can successfully work with Black people in counseling settings, he or she needs to be aware of a range of cultural and cognitive dispositions. This section explains common barriers to effective counseling with persons of Black African ancestry.

Cultural encapsulation is the practice of disregarding the influence of culture on therapeutic processes, which can lead to ineffectiveness with connecting with Black clients. Several authors have noted the effects of cultural encapsulation in psychotherapy (Estrada, Frame, & Williams, 2004; Leuwerke, 2005). Culturally encapsulated counselors may (a) define reality with one set of cultural assumptions and stereotypes about Black people, (b) be insensitive to cultural variation and view only one culture as legitimate, (c) have unfounded and unreasoned assumptions about other cultures, (d) overemphasize clinical techniques that they apply rigidly across cultures, and (e) interpret behaviors from their own personal reference (Ponterotto, Pedersen, & Utsey, 2006).

White privilege, or conferred dominance, describes the unearned societal rewards that Whites receive based on skin color (McIntosh, 1998). Unrecognized or poorly understood White privilege can diminish counseling relationships with Black clients. According to McIntosh, most White people are unaware of privileges because they are maintained across generations through denial. Neville, Worthington, and Spanierman (2001) posited that White privilege is an insidious and complex network of relationships among individuals, groups, and systems that operates in a racial social hierarchy. On the surface, it would appear that Whites reap only benefits from unearned racial privilege. However, there are a number of social and emotional consequences associated with receiving White privilege (Helms, 1995; Neville et al., 2001; Pinderhughes, 1989; Thompson & Neville, 1999). For example, Thompson and Neville (1999) reported that a group of White counseling psychology graduate students who had become aware of their unearned racial advantage experienced feelings of guilt, shame, and sadness. According to Pinderhughes (1989), people who realize White privilege may experience uncertainty and a sense of entrapment.

In cross-cultural counseling supervision, White privilege is associated with many racial issues, such as White supervisors being culturally unresponsive to African American supervisees and White supervisees becoming insubordinate with African American supervisors. In counselor training, Utsey, McCarthy, Eubanks, and Adrian (2002) observed that White privilege often manifests as White trainees speaking for themselves, in contrast to Black trainees who are often called on to speak for their entire race. In addition, Helms and Cook (1999) found that supervisors often attribute clinical errors to a client's pathology rather than to a White trainee's clinical skills in cross-racial counseling relationships.

White trainees who have an enhanced sense of their White privilege are more effective in negotiating cross-racial counseling situations (Utsey, Gernat, & Hammar, 2005). Helms (1997) posited that White counselor trainees can develop a "nonracist" White identity by accepting their "Whiteness" and acknowledging ways in which they benefit from White privilege.

Therefore, the task for counselor trainees is to become aware of how subtle White privileges are relevant to their experiences and impact their clinical work with African American clients (Utsey et al., 2002).

Color-blindness refers to racism that is reflected in color-blind racial attitudes typified by ignorance, denial, and a distortion of the reality that race plays a role in people's lived experiences (Neville et al., 2001). Bonilla-Silva (2002) identified the following four major schematic characteristics of color-blind racism: (a) principles of liberalism are extended to racial matters, (b) social and economic racial disparities are explained in societal terms (e.g., *dysfunctional family structure, deficient environmental conditions*, etc.), (c) racial stratification (e.g., residential and school segregation) is viewed as a naturally occurring phenomena, and (d) racism is asserted to be a thing of the past.

In the context of counselor training, White counselor trainees' color-blind racial attitudes are often manifest in the attitude that Black clients are no different from racial majority group clients (Utsey et al., 2005). When using color-blind attitudes, the White counselor trainee risks overlooking the role of racism and discrimination in relation to the client's presenting problem. Utsey et al. (2005) noted that color-blindness is unethical, since the Ethical Principles of Psychologists and Code of Conduct (American Psychological Association, 2010) mandates that practitioners address issues related to racism and discrimination as potential sources of distress for racial minority clients. White counselor trainees who adopt a color-blind posture toward their racial minority clients also tend to minimize the influence of their Whiteness on the counselor-client relationship. In addition, color-blindness is a major cause of the disproportionate number of Black people being diagnosed with severe pathology (Ridley, 1995).

Psychological Development of Persons of Black African Ancestry

Essentially, three forces make up the identity of persons of Black African ancestry: (a) expressions of African consciousness, (b) resistance to racism and oppression, and (c) adaptations to colonialism (Toldson, 2008). These three forces are omnipresent among continental and diasporic Black Africans. Within each force, there are countless manifestations through Black persons' personality, psyche, and behavior.

Expressions of African Consciousness

African consciousness embodies archetypal and ancestral wisdom in Black people's collective memory. Predisposition toward vital emotionalism, spontaneity, rhythm, naturalistic attitudes, physical movement, style, and creativity with the spoken word are cultural expressions that form the core of African consciousness. These characteristics interact to produce human behavior that registers images, sounds, aromas, and euphoria to the senses (Toldson & Toldson, 2001).

Expressions of African consciousness heavily influence Black people's subjective worldview. As a construct, African consciousness helps persons of African descent to attain optimal self-concept, self-esteem, and self-image (Constantine, Myers, Kindaichi, & Moore, 2004). African consciousness is the archetypal background from which diasporic Africans must formulate answers to questions of identity:

> Who am I? How do I see myself? Who defined my image, and was my image defined in a way to help me challenge, confront, and overcome adversity? Who do I come from? What can I do? What do I believe about my lineage and myself?

> Where am I going in life? And what does it mean when I become ill (sick, fail, transgress, addicted)? (Toldson & Toldson, 2001, p. 405)

Black communities use elements of African consciousness as an essential influence to serve as a balance or counterpart to the mind and body (Cervantes & Parham, 2005). This balance secures harmony, proportion, and symmetry with nature, self, and others. Spirituality is the basic underlining or constituting entity of the African conscious, embodying essential properties, attributes, and elements indispensable to their subjective worldview. The spirit is an immaterial sentient part of Black persons, providing inward structure, dynamic drive, and creative response to life encounters or demands. Recognition of the African consciousness, and the distinct way it manifest under various circumstances, is essential to African-centered therapeutic interventions. This holistic perspective makes healing a collective undertaking. Accordingly, the construction of reality is inseparably spiritual and material is essential to the African consciousness (Hatter & Ottens, 1998; Mphande & James-Myers, 1993; Tyehimba, 1998).

Contrarily, Western psychology emphasizes a material view of reality that focuses on awareness through the five senses. The Eurocentric perspective sees the world as an infinite number of discreetly different manifestations presenting as observable, material phenomena. Simply stated, while the Eurocentric paradigm might suggest, "Seeing is believing," the Afrocentric paradigm would suggest, "There is more than meets the eye."

Consistent with Afrocentric perspectives, many contemporary physicists and psychologists believe that a material conception of reality is outmoded (Cunliffe, 2006; Davis, 2005; Nelson, 2006). Spirit, in the African cosmos, rhythmically shapes things, ideals, animals, and human beings together in a representative whole of its essence (Cervantes & Parham, 2005; Constantine et al., 2004; Herrick, 2006; Toldson & Pasteur, 1972). When this rhythm is disturbed, the spirit is unsettled and manifests in the individual as anxiety, depression, or other mental or physical disorders (Blackett & Payne, 2005). Restoring this rhythm to achieve an integrative harmony within the self is the goal of African-centered approaches to therapy. These approaches form the backdrop to culturally appropriate therapeutic services delivered in the African American community (Vontress, 1991, 1999).

The absence of a "balanced focus" in modern-day medicine places the typical African American client in an *etiological dilemma* with respect to acquired illnesses. Finch (1990) insists that among traditional African people, "Without the psycho-spiritual cure—without reestablishing this sensitive harmony—the medicinal cure is considered useless" (p. 129). Finch goes on to say that African medicine has baffled scholars because it completely integrates the "magico-spiritual" and "rational" elements. The spiritual aspect of healing has been discredited among the modern-day scientific-minded scholars (Finch, 1990). However, Finch explains, modern medicine acknowledges that 60% of illnesses treated by physicians have a psychological basis, and interventions quite often involve pharmacologically inactive drugs—placebos.

In the Afrikan and Zulu worldview, one's values and purpose is placed on their "being" in the community/world rather than obtaining possessions. The quality of one's "inner essence" is determined by evaluating his or her behaviors and spirituality—ultimately defining his or her worth to the community. Afrikan worldview psychologists' (Ubuntu psychologist),

> overall function would be to (1) recognize Spirit in all aspects of life, (2) appreciate people's

> spiritual journey, (3) facilitate movement towards becoming one with the Creator, (4) help increase people's strength from their experiences, (5) keep people aligned with their purpose, and (6) acknowledge that people have purpose. (Washington, 2010, p. 37)

Zulu thought also suggests that certain disorders can specifically occur in Afrikans and they must be understood within context in order for balance and harmony of the self and community to exist (Washington, 2010).

Resistance to Racism and Oppression

Kessler, Mickelson, and Williams (1999) conducted a telephone survey that explored the impact of racism on mental health. The study revealed that the lifetime prevalence of "major discrimination" was 50% for African Americans, in contrast to 31% for Whites. In addition, major discrimination was associated with psychological distress. The authors concluded that racism and oppression adversely affect mental health and place African Americans at risk for mental disorders such as depression and anxiety.

The influences of racism and oppression on the psychological development of Black people are twofold. First, racism and oppression contribute to behavioral responses that signal concern about survival, which can either increase psychological distresses or promote unconventional survival mechanisms (Clark, Anderson, & Clark, 1999). In this view, Black people are not collectively injured by racism and oppression. Using ego defense mechanisms to illustrate, when responding to racism and oppression, some Black people might take a "middle-of-the-road" stance such as denial, intellectualization, or humor. A more harmful mechanism might be displacement, where a Black person will unconsciously redirect resentment for the oppressor to less threatening targets such as the family and community. Contrarily, sublimation is a healthy and productive reaction to racism, which involves refocusing negative feelings into healthy outlets of expression, allowing for creative solutions to problems.

In addition to extrapolations of psychoanalytic theory, several African theories have emerged to explain the impact of racism and oppression on Black people's psychological functioning. *Cultural trauma*, for example, describes slavery, lynching, and legal discrimination beyond their past institutional manifestations and asserts that these experiences are embedded in the collective memory of present-day Black people (Alexander, 2004; Eyerman, 2001). The legacy of cultural trauma is manifested in the destructive activities that occur in African American communities, including violence and substance abuse, which are also associated with symptoms of posttraumatic responses (Whaley, 2006). *Post-traumatic slave syndrome* asserts that positive and negative adaptive behaviors survived throughout generations of Black people from the transatlantic slave trade and other atrocities. Leary (2005) suggests reevaluating those adaptive behaviors and replacing maladaptive ones to promote healing in Black culture.

Other models of racism and oppression focused on more contemporary manifestations of racism. *Invisibility syndrome* for example is a more subtle form of racism and White privilege that engenders race-related stress (Franklin & Boyd-Franklin, 2000; Franklin, Boyd-Franklin, & Kelly, 2006). Finally, the presence of *historical hostility* resulting from slavery and discrimination is reported to contribute to a "unique psychology" among African Americans that may result in tension and mistrust of non-Black counselors (Vontress & Epp, 1997).

The second consequence of racism and oppression is more directly related to postcolonial institutions, including organizations that provide counseling services (Fairchild,

1991; Fairchild, Yee, Wyatt, & Weizmann, 1995). Mental health in American has roots in racism and oppression. During slavery, mental health professionals diagnosed runaways with drapetomania, meaning "flight from home mania" (Fernando, 2003). Black people who were content with subservience were considered mentally healthy.

Today, the attitude that persons of Black African ancestry should have psychomotor restrictions continues to pervade mental health systems. African American patients are more frequently involuntarily committed to psychiatric hospitals and administered psychotropic drugs (Schwartz & K. Feisthamel, 2009). In addition, persons of Black African ancestry continue to receive labels of borderline intellectual functioning and mental retardation on the basis of psychometric scales that were constructed based on a Eurocentric paradigm and normed primarily on persons of European descent (Hilliard, 1976, 1980).

Many conscious counselors are aware that current mental health systems are failing Black clients. In a counseling psychology doctoral class at an urban university, a professor asked his students in a Black psychology class to "raise your hand if you've ever oppressed your client." More than half of the students dejectedly raise their hands. With remarkable insight, the students realized that by simply following the rules of their employers, they were participating in less than optimal practices that contributed to their clients' oppression. Ways in which counselors and other mental health professionals routinely oppress their clients include (1) using biased psychological tests to inform counseling decisions, (2) writing or endorsing reports that emphasize deficits, (3) endorsing the use of psychotropic medication to suppress culturally or developmentally appropriate behaviors, (4) using the majority culture as the basis for behavioral norms, and (5) adhering to diagnostic classification systems without regard to cultural considerations (Toldson, 2008).

Adaptations to Colonialism

Persons of Black African ancestry have had to adapt to the language, customs, religious practices, educational pedagogy, economic philosophies, and geopolitical systems of European colonial tyrants (Loomba, 2005; Lyons & Pye, 2006; Turner-Musa, 2007; Valls, 2005). For centuries, European colonial empires extended its sovereignty over territory beyond its homeland, using Black African slave labor to cultivate the Americas and native Black Africans to build dependencies, trading posts, and plantation colonies. The colonizers imposed their sociocultural mores, religion, and language on Black people and adopted a corrupt set of values, including racism, ethnocentrism, and imperialism, which aim to justify the means by which colonial settlements were established.

In the relatively recent history of Black people achieving equal rights under the law in the Americas (i.e., 1964) and sovereign nationhood in Africa (i.e., 1950s–1970s), Black people have adapted, mastered, and innovated traditional European systems. Black people have added words and dialects to European languages, established educational institutions based on Eurocentric pedagogy, and maintained financial institutions based on *lassie faire* capitalism. A Eurocentric mind-set will lead many to assert that Black people are obliged to adapt and that adaptation should be effortless. In reality, adaptation is a cultural imposition to Black people worldwide. Imagine White Americans having to adapt to a system in which oratory mastery was required for college admission, bartering was the primary method of exchange, and laws were determined by a council of elders.

In the postcolonial era, there have been many critiques of the impact of colonialism and whether colonialism exists today. Colonialism permanently changed the social-cultural, geographic, political, and economic landscape of the world. Persons of Black African ancestry in Africa and the Americas continue to live as second-class citizens, whereas generations-old businesses and banks that financed acts of genocide and other atrocities reap residual benefits from the legacy of colonialism.

Colonialism has implications for counseling practice and research on Black people. First, the psychological impact of colonialism and survival of indigenous values among colonialized people influences counseling relationships. Second, cultural imperialism is a natural by-product of colonialism, leading many counselors to make assumptions about a client's traditions and values that are shaped by the majority culture. In addition to cultural imperialism, ethnocentrism, racism, White supremacy, and pseudo-scientific theories used to justify colonialism have lingered well past decolonialism and influence counseling research and practice.

Understanding the impact of colonialism requires investigating the environmental, historical, political, and social contexts to determine how Black psychology has developed over time (Jamison, 2009). Afrocentric and Eurocentric approaches, even with their contrasting views, provide insight into understanding African Americans (Belgrave & Allison, 2006).

Collectively, the three forces of Black peoples' psychological development embody the infinite diversity and the omnipotent potential of persons of Black African ancestry. These are the archetypal forces providing definition to their inner structures, mechanisms of endurance, dynamic drive, and ability to adapt to foreign environments. They represent the whole of Black people, illustrating past preeminence, and ensuring present perseverance and future consummation.

Mental Health

Conceptualizing Mental Health Problems

Successful treatment of a psychiatric disorder ushers in an accurate conceptualization and assessment of the problem. Difficulties conceptualizing Black peoples' mental health problems typically arise from the tendency of mental health professionals to assume individual autonomy, which suggests that individuals' problems originate and are perpetuated within each individual (Atkinson, Morten, & Sue, 1997). This assumption undermines the complexity of Black peoples' mental health problems.

A competent assessment of Black problematic behavior should not be limited to a description of mental and emotional deficits or to observations of externalized abnormal behaviors. Instead, an accurate assessment should extend to describe inherent responses to social and environmental conditions, in which the abnormal behavior might be a "normal" reaction. In other words, Black behavioral pathology is sometimes best explained as a consequence of dynamic ecological systems rather than the result of intrapsychological deficits.

On a basic level, when considering the mental health status of Black people, one must be mindful of the universality of diagnoses, aware of biases in mental health procedures, and sensitive to diversity. Universality is the idea that disorders found in some cultures may manifest differently or be obsolete in other cultures (Lee, 2002). However, to achieve true authenticity in conceptualizing the mental health status of Black people, professionals must relate to their

subject with the holism that is consistent with African-centered perspectives and its Western adaptations, such as existentialism (De Maynard, 2006; Epp, 1998) and positive psychology (Strümpfer, 2005, 2006).

Nontraditional approaches might require clinicians to grasp a clients' mental health using insight and intuition, intellectual creativity, and abstract reasoning. This might sound irrational to a staunch adherent to the scientific method. However, in practice, using strict logic to understand mental health often reduces the client to a blunder of fragmented inferences, rent asunder from the whole in which he or she belongs. The mental health status of Black people should be viewed within the context of their history and nomenclature and of the complex of forces that influence their cultural identity.

Specific Mental Health Challenges

Prevalence of Mental Health Disorders. The Epidemiological Catchment Area studies (ECA) and the National Comorbidity Survey (NCS) have been used to assess the prevalence rate of mental health disorders across cultures (Galea & Cohen, 2011). The ECA indicated that Black people have an overall higher prevalence of mental health disorders; however, when controlling for socioeconomic factors, most differences are statistically eliminated. Both the ECA and NCS found that African Americans were less likely to suffer from depression. The ECA indicated that African Americans are more likely to suffer from phobia than were Whites.

Using several studies, the Department of Health and Human Services concluded that African Americans are overdiagnosed with schizophrenia and underdiagnosed for depression and anxiety (Snowden, 2012). Schwartz and Feisthamel (2009) found 27% of African American clients were diagnosed with psychotic disorders, compared with 17% of all European American when presenting for treatment. Schizophrenia and affective disorders specifically are uniquely associated with forces that shape Black people's psychological development and must be carefully examined within a cultural context.

Fernando (2003) revealed that reports suggesting high rates of schizophrenia among African Americans began to appear in the 19th century. By the mid-1900s, the overdiagnosis of schizophrenia was firmly established, while the diagnosis of bipolar disorders began to decline. Interestingly, British studies during the same time period revealed similar diagnostic trends, although reports of schizophrenic behavior in Africa were rare (Fernando, 2003). Recent findings suggest that the overrepresentation of Black people with schizophrenia is primarily due to diagnostic biases rather than to true differences in the population. Today, the excessive and inaccurate diagnosis of schizophrenia may be attributed to Black people's nonmaterial conception of reality, spirituality or religiosity, and/or "healthy paranoia," originally defined as a generalized reaction to racism, which is perceived as necessary for normal adaptive functioning in oppressive environments (Metzl, 2009; Whaley & Hall, 2009).

Racial biases that permeate mental health systems may also contribute to the underdiagnosis of depression. Fernando (2003) noted that in the past, the lower incidence of depression among African Americans has been attributed to frontal lobe idleness, which caused Black people to lack higher-order emotional functions (Carothers, 1953) and resulted in a tendency for Black people to respond to adversity with "cheery denial" (Bebbington, Hurry, & Tennant, 1981). These blatantly racist explanations are comparable to recent findings that clinicians tend to minimize emotional

expressions by African Americans (Das, Olfson, McCurtis, & Weissman, 2006), which leads to fewer Black people being diagnosed with depression. Das et al. (2006) suggested that clinicians circumvent cultural influences by examining "somatic and neurovegetative symptoms rather than mood or cognitive symptoms" (p. 30). This approach undermines Black people's psychological functioning and implies that clinicians should ignore symptoms that they do not understand rather than broaden their cultural lenses.

Suicide. Research on suicide within the African American community has continued to increase. African Americans generally have lower suicide rates when compared to Caucasians, despite significant economic and social disparities within the Black community (Davidson & Wingate, 2011; U.S. Department of Health and Human Services, 2001). Recent research found that African Americans significantly indicated higher levels of protective factors against suicidal behavior than did Caucasian counterparts (Davidson & Wingate, 2011).

However, after a review of literature, Spates (2011) concluded that in African American women who suffered a history of particular mental disorders, depression, physical and emotional abuse, and alcohol and substance abuse have all demonstrated to considerably increase the risk of suicidal behaviors. Walker, Alabi, Roberts, and Obasi (2010) found that college students who were more African centered along with experiencing depressive symptoms disclosed having fewer reasons to live. Additional findings, contradicting previous literature, indicated that hopelessness was not associated with suicidal behaviors among African American young adults (Walker et al., 2010).

Exposure to Violence and Posttraumatic Stress. African Americans are more likely to be a victim of a violent crime than any other ethnic or racial group. McDevitt-Murphy, Neimeyer, Burke, Williams, and Lawson (2012) found that a disproportionate number of murder victims in the United States are African American, which compounds other public health concerns such as grief, loss, and trauma. African Americans significantly experience clinical outcomes such as posttraumatic stress disorder (PTSD), complicated grief, depression, and anxiety (McDevitt-Murphy et al., 2012). Extended social supports, properly strict parents, and a hearty self-assurance contribute to resiliency among Black youth (Thompson, Briggs-King, & LaTouche-Howard, 2012).

Vulnerable Segments of the Population. Persons of Black African ancestry are susceptible to a variety of mental health problems because they are overrepresented in the most vulnerable segments of the population. Although only 13.8% of the U.S. population, African Americans make up between 38% and 44% of the homeless population (Cortes, Henry, de la Cruz, & Brown, 2012) and nearly half of state and federal inmates (Carson & Sabol, 2011). In addition, African Americans are at a greater risk for mental health care disparities because they are less likely to have health insurance and less likely to obtain proper mental health treatment (Simning, Wijngaarden, & Conwell, 2011).

Simning et al. (2011) found that African Americans residing in public housing had a higher lifetime prevalence of mental illness than African Americans not residing in public housing. Results also indicated that African Americans residing in public housing had higher levels of anxiety and substance use disorders than African American non-public housing residents (Simning et al., 2011). Additionally, a recent study found that among African American sexual assault survivors,

there is increased poverty linked to discriminating negative mental health outcomes such as depression, PTSD, and illicit drug use (Bryant-Davis, Ullman, Tsong, Tillman, & Smith, 2010).

Furthermore, there is increasing evidence that persons who experience discrimination have an elevated risk for psychological distress and mental issues; researchers have found higher percentages among African Americans who have experienced discrimination than among other minorities (McLaughlin, Hatzenbuehler, & Keyes, 2010). Moreover psychiatric disorders constitute another important factor that exposes African Americans to adverse social situations (Jin et al., 2008). Schwartz and Feisthamel (2009) indicated that African American participants had a significantly greater chance of being diagnosed with childhood disorders than did European American participants. Results of this study also demonstrated that counselors disproportionately diagnose African Americans with psychotic and childhood disorders (Schwartz & Feisthamel, 2009).

Educational Issues. Education is the key to correcting longstanding social and economic racial disparities in the United States. One in three African Americans without a high school diploma lives below poverty, and less than 10% achieve a middle-class income (Jackson, 2010). If black male ninth graders follow current trends, about half of them will not graduate with their current ninth-grade class (Jackson, 2010), and about 20% will reach the age of 25 without obtaining a high school diploma or GED (Ruggles et al., 2009).

The High School Longitudinal Survey asked parents a variety of questions that related to their ninth-grade child's potential to complete high school (LoGerfo, Christopher, & Flanagan, 2011). When comparing each variable across race and gender, Black students are at the greatest risk for not completing high school. Specifically, Black males are more than twice as likely to repeat a grade and be suspended or expelled from school as White males. Black males were also more likely to receive special education services and have an individualized education plan (IEP) and the least likely to be enrolled in honors classes. Parents of Black students were the most likely to have the school contact them because of problems with their son's behavior or performance (Toldson & Lewis, 2012).

Healing Practices and Experiences With Mental Health Treatment

Community-Based Treatment. Comprehensive mental health treatment programs endorse rendering services in the clients' homes, schools, and communities (Bennett, 2006; Teicher, 2006; Toldson & Toldson, 2001). Community-based approaches could address Black people's reluctance to seek professional mental health care in traditional settings, reduce the ethnocentric biases among care providers, and help care providers to have a better context for clients' problems. From an African-centered perspective, community-based interventions could represent a progressive step toward communalizing the process of mental health delivery.

Group Therapy. Group therapy and community-based interventions are more consistent with the African values of collectivism and communalism (Toldson & Toldson, 1999; Vaz, 2005). The group combats the sense of isolation that is a product of individualism, while it promotes a sense of oneness, consistent with the African ethos of oneness of being. The idea of universality (Yalom & Leszcz, 2005) comes close to the African idea of oneness of being, and creating this sense within the group requires culturally appropriate interventions and procedures.

Collectivism in Counseling. Black peoples' collectivist orientation is evident in their healing preferences. Specifically, persons of Black African ancestry are more likely to rely on family and friends to cope with personal difficulty (Logan, 1996; Ruiz, 1990). The "brotherhood/sisterhood" concept among African Americans elevates family extensions to the status of core family members, and solutions to personal difficulties often involve meaningful exchange throughout the extended family. Thus, Black people in therapy may feel compelled to elevate the status of the clinician to an extended family member before actively engaging in the therapeutic process.

Naturalistic Healing. This is another value evident in mental health healing practices among Black people. In a review of the literature, U.S. Department of Health and Human Services (2001) found that African Americans prefer counseling to drug therapy and are more likely to have concerns about the side effects, effectiveness, and addiction potential of medications (Cooper-Patrick et al., 1997; Dwight-Johnson, Sherbourne, Liao, & Wells, 2000). Research has also revealed that African Americans tend to take an active approach to facing personal problems and are less likely than Whites to use any professional services to deal with mental health issues (Bean, Perry, & Bedell, 2002). In this view, Black people might prefer a process of healing that feels more natural, emphasizing normal adjustments to life transitions and less intrusive or "technical" approaches, such as medication or a formal brand of therapy.

Summary and Conclusions

Psychological health care must begin to affirm a biomedical ethic that is sensitive to perspectives of Africans and diasporic descendants. The process can be enhanced by making accommodations for the expression of belief patterns, thoughts, and sociocultural customs indicative of the presence of an African identity in the behavior of African people. These must be woven into theoretical points of departure in the provision of quality psychological health care.

The impact of the interrelationships among environmental conditions and sociopolitical dynamics on the definitions of normal mentally healthy behavior of oppressed Africans must be accounted for in diagnostic decision making relative to clients of African descent.

It is essential to increase the presence of psychological health care providers, who embrace the understanding that it is therapeutically relevant, if not necessary, to develop an African identity in the psyches of African people. These providers should understand the sociopolitical influences of the dominant perspective of psychology in order to help affirm a bioethical perspective that is sensitive to the African ethos.

Recognizing group identity and collective responsibility as real and deducible phenomena within the culture of African American people is consistent with the embrace of an African ethos. This can be made operational by soliciting consent for biomedical involvement of the individual from relevant groups, including the family, church, social/civic organizations, associations, friends, fraternal and sorority societies, and/or sociopolitical organizations (the tribe) with which the individual affiliates in the manifestation of his or her identity as a group member. Such a procedure is advisable, not only out of respect for these African values but also in recognition of the low power quotient afforded the ordinary citizen of African descent.

Additionally, it is important to recognize that most African Americans have to be, at least to

some extent, bicultural and that this status creates a unique set of mental health issues related to self-esteem, identity formation, and role behavior to which systems of psychological health care must appropriately respond. Differentiating between the symptoms of intrapsychic stress and stress arising from sociopolitical powerlessness and limited economic resources is an essential clinical skill of the psychologist who claims sensitivity to a biomedical perspective that is consistent with the African ethos.

Learning the culturally different indicators for depression, anxiety, attachment and loss, identity confusion, and other less inflammatory diagnostic indicators to more accurately replace those that are excessively used such as schizophrenic, borderline personality, oppositional defiant, conduct, and attention deficit disorders in African American clients is a diagnostic imperative. Moreover, subscribing to diagnostic nomenclature introduced by African American psychologists, which also defines accommodationist behavior of the acculturated African American as maladaptive, must be considered in diagnostic formulations about the mental health of African Americans.

Accepting spirit and unseen forces as meaningful phenomena in the life realm and decision-making processes of the majority of African people is significantly important. Spirit is an entity that has to be reconciled and/or accommodated in formulas for clinical insight and understanding.

In behavioral, as in biomedical research, there is a tendency to recruit participants disproportionately from particular groups within the social system (Toldson & Toldson, 2001). Groups that are dependent or powerless by virtue of their age, their physical and mental condition, their minority status, their social deviance, or their condition of captivity within various institutions are heavily recruited as research participants.

Given the African American power deficiency within the social system, the truly voluntary nature of consent becomes problematic for Black research participants. The exploitation of Black research participants, usually to demean the Black community, is a situation that must be brokered at the sociopolitical level. Power bases in the Black community to sign off on matters of consent would rightfully bring the control of such research within the bounds of the African American community in concurrence with its collective nature.

The medical-based professions emanate from Africa, brought to excellence in antiquity by the Egyptians (Finch, 1990). Racism within the biomedical sphere of intelligence must be confronted and purged. Purgation should be followed by an impregnation with the spirit of Africa. The degree of confrontation, purgation, and impregnation will be measured by the degree of African consciousness that is cultivated within the African American community.

African and diasporic scholars, and others of goodwill, who are possessed with the ethos of doing what is good, right, fair, and just in the interest of the physical and mental health of African people everywhere must cultivate clinical procedures that promote comfort with the existence and therapeutic desirability of an African consciousness in the psyches of African descendants. Cultivating its expression is consistent with good and right action in the delivery of quality mental health care to citizens of African descent.

▣ Note

1. In this chapter, the terms *persons of Black African ancestry* or *Black people* are used to describe persons worldwide whose ancestors were indigenous to sub-Saharan Africa. The term *African Americans* is used to describe Black people in America, usually the United States of America.

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