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ARTICLE

Race in the Room: Issues in the Dynamic Psychotherapy of African Americans

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Abstract Race enters into psychotherapy in ways that parallel its operation in society. This article offers in a 'narrative of race' an integrated model of psychological stress that is used as a guide in the biopsychosocial formulation of a case presentation. Negative internal models of relationships include that of the black matriarch, the emasculated black male, the white authority figure and the black self-rejected image. In the discussion of an African American patient in psychotherapy, we use these negative internal models to address two controversial issues. First, to what extent are racial conflict and negative internal models of relationships incorporated into the black patient's dysfunctional life issues? Second, can black patients resolve issues caused by their need to function in a racially stratified society through a therapeutic alliance with therapists from other cultures? We support the position of cross-race therapy dyads with the acknowledgment of race in the consultation room. African American patients can receive effective therapy from any culturally oriented therapist who facilitates the resolution of racial conflict. From this foundation, we propose a dynamic model in which the therapist enters the experience of the African American patient and establishes fixed points of reference for the proper detection of transference/countertransference issues.

Key words African American • culture • psychotherapy • race • relationships

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INTRODUCTION

The treatment of African Americans in the psychiatric literature is marred by its early defense of racism, when diagnoses such as 'drapetomania,' the 'flight-from-home-madness,' were given to runaway slaves in the antebellum South (Griffith, 1977). A century later, references to African Americans are still disparate. Studies of treatment outcomes substantiate the assumption that therapy is often inefffective with ethnic minorities (Acosta, 1980; W. A. Adams, 1950; Dreger & Miller, 1968; Morrow, 1975; Rosen & Frank, 1962). Blacks are cited as not appropriate for psychotherapy in that they fail to meet criteria of verbal fluency, motivation and 'psychological mindedness.' They are deemed crisis oriented and non-introspective, valuing environmental change rather than personal change. Blacks are further portrayed as seeking concrete outcomes rather than abstract goals with future orientation, or as preferring collective enterprise and interdependence versus independence and self-actualization (Adebimpe, 1994; Ridley, 1984).

Studies examining the therapeutic dyad are not without racial bias. White reviewers predominantly state that neither race nor ethnicity impact treatment outcome (Abramowitz & Murray, 1983; Atkinson, 1983; Hall & Malony, 1983; Sattler, 1977); black investigators hold the opposite view (Butler, 1975; Morten & Atkinson, 1983; Parham & Helms, 1985). There have been extreme exceptions to these positions. B. Jones and colleagues (1970) and Thomas (1970) argue that the cross-race dyad poses insoluble problems and that the white therapist's efforts will be destructive to the black patient. And despite black preference for racially matched therapy, there have been no studies demonstrating that African American patients do substantially better in treatment when seen by therapists of the same racial group (Pena & Koss-Chioino, 1992). Studies do show that empathy develops more naturally and there is less negative countertransference when black therapists engage black patients (Griffith, 1977; D. W. Sue & Sue, 1990). However, Comas-Diaz and Jacobsen (1991) point out that the overidentification with the patient's social situation occurring in same-race dyads may result in reinforcement of the patient's pathology. As a minimum, there is a loss of clinical objectivity and thus inattention to the individual pathology that the patient brings to treatment (Cooper, 1973; Fischer, 1971; Grier & Cobbs, 1968). If African Americans require racially matched therapy, major civil rights issues would be encountered in triaging and assigning minority patients to culturally specific therapies while majority patients are referred to standard treatments. Moreover, creating an adequate array of culturally specific therapies, required to bring an equal quality of mental health care to all diverse citizens, would be an organizational and quality assurance task of daunting proportions (Foulks et al., 1995; Littlewood, Moorhouse & Acharyya, 1992).

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The isolation of blacks from other cultures in the therapy process is further exacerbated by the politically correct concept of raceless therapy. This approach assumes that all people regardless of race, ethnicity or culture develop along uniform psychological dimensions. According to this postulate, there are no cultural biases in outcome or requirement for race or sex pairing between analyst and analysand (Griffith & Jones, 1979; E. E. Jones, 1978; Korchin, 1980). Social scientists describe an 'illusion of color blindness' to which a therapist may ascribe when assuming that the black patient's culture is the same as that of other cultures (P. L. Adams, 1970; Anosike, 1982; Cooper, 1973; Sabshin et al., 1970; Sager et al., 1972). Griffith (1977) identified three core problems with the color-blind therapeutic approach: (i) it disregards the central importance the patient's blackness has for him; (ii) it ignores the impact of the therapist's whiteness on the patient; and (iii) it abstracts the black patient from the social realities of his experiences.

Race continues to be a sensitive issue in the discussion of psychotherapy. Holmes (1992) points out that working on the problems of race 'from the outside,' as in the community, is favored over the engagement of these issues 'on the inside' of the consultation room between therapist and patient. This implies that social reform is more readily accepted than actual feelings of parity among the races.

In this article, we offer a multicultural solution that does not compromise the goals established for treatment outcome or patient satisfaction. The psychological stress of being black in America is formulated into a narrative of race that may be used as a guide for constructing a specific biopsychosocial formulation of African American patients in psychotherapy. We address two controversial issues. First, to what extent are racial conflict and negative internal models of relationships incorporated in the black patient's dysfunctional life issues? Second, can black patients resolve issues caused by their need to function in a racially stratified society through a therapeutic alliance with therapists from other cultures? These psychotherapeutic questions echo the societal concerns raised in Glazer's (1998) recent book, *We are all multiculturalists now*. Glazer writes from the position of a sociologist who once hoped that African Americans would be assimilated into mainstream American culture. He now acknowledges a multicultural outcome for African Americans that leaves them very much segregated in a racially stratified society. We attempt to understand the impact of this black reality on psychotherapy.

The Narrative of Race

The only reality is the patient's reality, and there is a distinct reality of being black in America. For many African Americans, the psychodynamic

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formulation offering a rationale for the development and maintenance of dysfunctional life patterns includes an inflexible narrative of race.

Rendon (1993) proposes that there are disorders of ethnicity just as there are disorders of identity. In an environment of extreme ethnic pathology, primitive defenses prevail. Psychological defenses may be seen as a hierarchy of mental coping processes that attempt to obtain distance from experiencing the painful event or unwelcome ruminations and feelings about past events. When an individual's ethnic identifications are conflicted, the internal response is to mobilize defense mechanisms such as denial, projection and displacement to deal initially with the psychological dissonance and discomfort (Perry & Cooper, 1989; Smith, 1989, 1991). Maladaptive patterns in a patient's internal models of relationships influence interactions with others, expectations and self-perception. For African Americans, three primary internal models drive psychological defenses. These are the internal parental models, the internal model of whites and the internal model of blacks. One of the problems with maladaptive defenses is that they lead to limitations on information needed for adaptation. These defenses often impair the ability to resolve interracial conflict and leave the patient more vulnerable to being traumatized in future encounters with whites. Defense mechanisms may persist even when hostility is no longer a risk. Myers (1982) suggests that prolonged exposure to stressful conditions may lead to a chronic state of overreactivity to events. Situations that are in fact benign for the individual may be experienced as stressful and threatening because of the perceived threat of discrimination.

Internal Parental Models

Substantial anger is frequently experienced toward the demands of intrusive mothers from matriarchal single parent homes while the absent father role is unjudged (Balkwell et al., 1978; Hobbs, 1985; Lander, 1972). Attempts to dispel this model argue that the myth of the black matriarch is based on overinterpretations of the effects of poverty on family structure and incidence of father absence (Staples, 1970). The internal model of father is a structure absent or emotionally detached from the needs of the child, leading to negative expectations of others (Balkwell et al., 1978). Black men maintain that they have been castrated by society but that black women somehow escaped this persecution and even contributed to this emasculation. This is allegedly substantiated by the disproportionate advancement of black women over men in the black middle class. Both parental models influence development through difficulty maintaining a sense of self as a separate and autonomous person, and having needs from the external environment with little expectation of response. Defenses

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developed in relationships with the intrusive mother or the absent/passive father become rigid and obstruct adaptation to new circumstances. These defenses drive a host of behaviors: fear, anger, self-defeat, servility and avoidance.

Internal Model of Whites

The stressful effects of social oppression on members of disadvantaged groups are well documented (D. B. Dohrenwend, 1967; B. P. Dohrenwend & Dohrenwend, 1974; Myers, 1982; Smith, 1985). While multiple sources of oppression and deficiency substantially affect an individual's experience of life, it is the internal model of whites that evokes significant anxiety within the African American's psychological capacities. This image is distorted by the power and privilege ascribed to representations of a superior class. It is difficult to appreciate how extensively the residual bonds of slave ownership prevail in the ego structure, or how this internal model is updated with a politically correct self-image. In Kleinian theory, there is a connection between primitive fantasy and racism (G. S. Klein, 1976). Doctrines of white–black and superior–inferior stratification are conceptualized as projective expressions of unconscious wishes. A similar view is held by Fischer (1971), who wrote that the black–white difference between the analysand and analyst is a significant and visible structure upon which the more basic and dynamic infantile fantasies are projected. Despite political and social reform, racial conflict is perpetuated in the unconscious motives of the opposing cultures.

The fear of inadequacy and the need to prove parity with peers may increase internal anxiety. Unconscious expectation of difficulties with whites may lead African Americans to avoid or minimize contact to protect themselves from loss of self-esteem. Another response to this unconscious expectation is servility. Submissive posturing and overcompliance with the wishes of perceived authority figures demonstrate concession to the traditional expectations of whites. Many African Americans constrain within their person a degree of anger towards the majority group. Aggressive acts clearly reflect this hostility, but often there are more subtle, self-defeating behavioral manifestations of anger. This is frequently the case with blacks who demonstrate great potential for achievement, then sabotage their own success by creating problems to highlight imperfections and prejudice in society or their work environment.

Internal Model of Blacks

African Americans appear to have a central conflict between racial pride and an underlying image of self as inferior, primitive and 'nonwhite.'

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Negative images of 'thick lips and thick minds' are portrayed in the chants of children at play and reinforced by low academic expectations. Social scientists refer to a 'pan-stupidity' syndrome, ascribed to the fear of being misunderstood, not accepted, considered ignorant or misled in relations with whites, no matter how benign they appear (Mayo, 1974; Nobles, 1976). The power of negative stereotypes is more pervasive than its influence on white perception of blacks as drug dealers and welfare mothers. It extends to the core of a value system in which unacceptable behavior is 'acting black,' and beauty is 'looking white' (Neal & Wilson, 1989). In its extreme, the negative image evokes a sense of shame for one's blackness. Helms (1986) defines racial identity as the portion of a person's world-view that is shaped by society's manner of attributing value to the socially ascribed group. Negative ethnic identity is characterized by using the majority group's standards as a means to judge and to accept or reject oneself (Smith, 1991). Hence the aesthetic reinforcement of 'good hair' versus nappy hair, and the preference for lighter skin color, mirror negative ethnic identity. In *The rage of a privileged class*, Cose (1993) asks, why would people who have enjoyed all the fruits of the civil rights revolution – who have Ivy League educations, high-paying jobs, and comfortable homes – be quietly seething inside? To answer that question is to experience America as a land filled with attitudes, assumptions and behaviors that make it virtually impossible for blacks to believe that the nation is serious about its promise of equality, even for those who have been blessed with material success. The internal negative models described in the narrative of race offer an explanation of how these attitudes affect the African American psychological being. The following case illustrates these principles.

A Case Example

Ms B is a 40-year-old single African American woman in a professional school who presented with complaints of isolation in her academic program. Specifically, she felt that she had no one with whom she could talk. She complained of poor sleep with middle and terminal insomnia, tearfulness, depressed mood, decreased energy, decreased concentration and intermittent suicidal ideation over a 2-month period. These symptoms started in the setting of a difficult school rotation where she felt singled out by the supervisor. The patient expressed feelings of hopelessness, stating that despite her education and hard work, she could be reduced to 'a Negro' by any white person. She complained of being racially isolated throughout her life. She was often the only minority in her private school classes, a prestigious women's college and graduate school. However, Ms B denied any prior history of depressive symptoms. She described her baseline self as an energetic, perfectionistic, high achiever who could do anything. She

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denied any history of an excessively irritable or euphoric mood, racing thoughts or pressured speech. Ms B also denied any psychotic symptoms, such as auditory or visual hallucinations. There was no known family history of alcoholism, suicide or sociopathy, although her mother had several periods of symptoms consistent with depression for which she was never treated. On examination, Ms B was reserved and guarded with pronounced sadness, decreased eye contact and little inflection in her voice.

The major stressors for Ms B appeared to be her intense sense of loneliness and loss of self-esteem during conflicts with her supervisor. The fact that the supervisor is white represents significant distress in the way the patient interprets his actions towards her, regardless of their racial intent. Ms B's affective, cognitive, behavioral and vegetative symptoms are perhaps indicative of an endogenous type of depression. Because of her earlier experiences with whites, she has difficulty trusting authority figures to be fair. She views herself as inadequate, defective and unlovable. Her primary defenses are regression, introjection, isolation of affect and intellectualization. Ms B's socio-cultural background instilled in her a basic belief in the value of hard work, stoicism and self-reliance with little dependence on extrafamilial sources of support. Psychotherapy for Ms B would be complicated by her cognitive style, her conflicts over dependency and autonomy, and her resistance towards a white therapist.

In early sessions, she explained that her feelings of alienation, because of her race, were a consequence of her need to protect herself due to mistrust of the intentions of others. Ms B established the multiple meanings being black had for her. Blackness was therefore something that made her stand out. Over the course of therapy, she came to accept her part in socially isolating herself from peers and followed a cognitive plan to connect with classmates. She came to see that her suspiciousness was healthy when it promoted caution in racially biased situations, but unhealthy when benign situations were misinterpreted. We questioned whether her need to prove parity was a defense against acceptance of herself as a black woman. As depressive symptoms subsided, she found herself able to relate to groups of people in a new way – no longer as an outsider, but as a participant.

Discussion

Recent studies estimate the prevalence of depression among black women as twice that for white women (Gazmararian et al., 1995). There has also been increasing recognition that ethnicity and culture play a role in the presentation, diagnosis and treatment of psychological problems (Bernal & Castro, 1994). To what extent are racial conflict and these negative

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internal models of relationships incorporated into the black patient's depressive symptomatology? Dysfunctional life patterns may have precipitated a number of negative schemas, which are amplifications of pre-existing learned behavior and cognitive patterns. As negative life events increase, judgments about close relationships become less favorable (A. C. Jones, 1985; Tesser & Beach, 1998). The experience of racism has undoubtedly contributed to emotional distress and psychological disease for African Americans. Black patients may have defended against early negative encounters with whites by suppression and denial. This impairs the patient's ability to resolve the experience and leaves the patient more vulnerable to be traumatized by future encounters with whites.

The biopsychosocial model of psychiatric disease postulates that psychopathology is the final common pathway of three determinants: (i) biological predisposition, (ii) individual characteristics, and (iii) the adaptive and adjustive reactions of a fully formed personality to stressors and deficiencies imposed from the external environment (Anda, 1984; D. B. Dohrenwend, 1967; E. E. Jones, 1978; Smith, 1989). In the case of Ms B, there is biological predisposition, characteristics of dependency and autonomy, and social factors including stressful life events, low self-perception and less perceived support (isolation).

The question in the case of Ms B is common to many African American patients in cross-race therapy: can blacks resolve identity issues caused by their need to function in a racially stratified society through a therapeutic alliance that includes other cultures? As this vignette demonstrates, when discussing racial issues and engagement in psychotherapy, the issue of racism is an inevitable factor interwoven with multiple other concerns when the patient is black and the therapist is white (Foulks et al., 1995; S. Sue, 1990). Recognizing the influence of culture and ethnicity within the fabric of each individual patient's problems allows integration of the patient's experience into the process of therapy and the content of interpretations (Casimir & Morrison, 1993). It is important to employ strategies that minimize the perception of ethnocentricism or institutionalized attempts to devaluate the black culture. The existential approach described by Havens (1974) enables the clinician to enter the experience of people with cultures different from self. This requires exclusion of preconceptions that the patient's values and frame of reference are the same as those of the therapist (Tyler et al., 1985).

Of particular relevance are questions about the interrelations among individual and ethnic factors as they influence people's functioning. These include ethnic group identification, reference group perspectives, degree of assimilation or acculturation, and minority or majority group status. The strength of an individual's ethnic identity either assists or impedes the patient in completing identity developmental tasks and resolution of

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internal racial conflict (A. Jones & Seagull, 1977; Ridley et al., 1994; Smith, 1991). Numerous models assess race and ethnic identity as therapy variables (Atkinson et al., 1986; Cross, 1978; Morten & Atkinson, 1983; Parham & Helms, 1981; Pomales et al., 1986; Tyler et al., 1985). For example, the ethnic validity model developed by Tyler and colleagues (1985) addresses convergence, divergence and conflict between different ethnic world views. Individual attitudes about one's blackness affect perceptions and responses to self and environment. The model is noted for recognition, acceptance and respect for the commonalities and differences in psychosocial development and experiences among people with different cultural heritages. Another concept that lends itself well to application in dynamic psychotherapy is the Cross developmental model of racial identity (1978). Cross used the concept of stages of identity to describe the different ways in which black people may resolve the identity issues caused by their need to function in a racially stratified society. For example, the pre-encounter stage is characterized by a devaluation of black culture. In the encounter and immersion stages there is increasing awareness and pride in black culture. And in the internalization stage there is inner security with one's blackness and tolerance for other cultures. In a study by Pomales and associates (1986) black patients were assessed by their level of racial identity and this level was linked to patient satisfaction and psychotherapy treatment outcome. It was noteworthy that patients in the encounter stage placed a high value on culturally sensitive counselor behavior, described as therapy which acknowledged the patient's blackness and showed openness to exploring cultural components of the problem.

Is it politically correct not to fully interpret intrapsychic conflicts in the face of racial explanations offered by therapy patients? It is more difficult for ethnic minorities to achieve good outcome from psychotherapy when their racial conflicts are not resolved. African American patients can receive effective therapy from any culturally oriented therapist who facilitates the resolution of racial conflict. It is not the race of the therapist but the acknowledgment of race that is crucial to the therapeutic interaction. Dynamic psychotherapy should recognize the influence of culture and ethnicity regarding the patient's emotional problems (E. E. Jones, 1978; S. Sue, 1977). Consequently, the integrity of the patient's diverse heritage and identity are acknowledged and respected. By integrating the contribution of ethnic circumstances on life events and psychosocial patterns, dynamic therapy neither systematically advantages nor subjugates any particular heritage.

We support cross-race therapy dyads with the acknowledgment of race in the consultation room. The pattern of exchange involved in therapy can provide a prototype of cross-ethnic exchanges (Tyler et al., 1985). Many blacks enter therapy to improve functioning within mainstream America

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(adaptation) without loss of ethnic identity (assimilation). In the dynamic model of psychotherapy, the therapist assumes the internal frame of reference of the patient and perceives the world as the patient sees it. The problem is articulated from the patient's perspective. This allows increased empathy and the ability to communicate empathy to the patient (Casimir & Morrison, 1993; Ibrahim, 1985). The patient in cross-ethnic psychotherapy may establish early transferences based on previous formal relationships where self-disclosure was kept to the minimum required to transact an interaction (Foulks et al., 1995). One approach used in cross-ethnic psychotherapy to overcome this resistance is having the therapist use more informal language when possible (Allen, 1988; Russell, 1987). Another method is to encourage patients to talk in therapy as they talk to their close associates (Rozensky & Gomez, 1983). The more knowledgeable the therapist can become regarding differences in use of vocabulary, communicative gestures, expressions of distress and personal–culturally based values, the better will be the therapeutic alliance (Baker, 1988; Brantley, 1983; Spurlock, 1982).

Minimization of cultural problems does not imply that treatment should always match cultural expectations and norms. The primary goal of therapy is to provide patients with new learning experiences. Knowledge of culture allows therapy to proceed toward resolution that improves adaptability. Techniques to minimize cultural effects must be linked to the process that results in specific therapy outcomes. Ms B's references to race provided the therapist with additional points of entry to transference reactions. Comas-Diaz and Jacobsen (1991) coined the term '*ethnocultural transference*' to refer to the major therapeutic response that may arise for patients in intra-ethnic dyads. Although ethnocultural similarities and differences may impede rapport, they may also serve as catalysts for addressing issues such as trust, anger, acknowledgment of ambivalence and acceptance of disparate parts of the self. Race was used by Ms B to express transferences that represented powerful early feelings toward white people in her life. In dynamic therapy interpretation of these projections onto the white supervisor allowed the patient and therapist to explore transference meanings of race. For example, Holmes (1992) suggests that it is possible that a black patient would be inclined to experience the whiteness of the therapist as a prized representation of an idealized lost, never-achieved object. An outcome goal achieved by Ms B was to reach internalization, where the racial identity becomes a flexible narrative. The case illustrates the point of many epidemiological studies, that racial issues are a major contributor to psychopathology. Outcome studies now need to demonstrate the benefits of psychotherapy in resolving racial conflict and modifying negative internal models of relationships both in cross-race and similar-race dyads.

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References

Abramowitz, S. I., & Murray, J. (1983). Race effects in psychotherapy. In J. Murray & P. R. Abramson (Eds.), *Bias in psychotherapy* (pp. 215–255). New York: Praeger.

Acosta, F. X. (1980). Self-described reasons for premature termination of psychotherapy by Mexican American, Black American, and Anglo-American patients. *Psychological Reports, 47*(2), 435–443.

Adams, P. L. (1970). Dealing with racism in biracial psychiatry. *Journal of the American Academy of Child Psychiatry, 9*, 33–43.

Adams, W. A. (1950). The Negro patient in psychiatric treatment. *American Journal of Orthopsychiatry, 20*, 305–310.

Adebimpe, V. R. (1994). Race, racism, and epidemiological surveys. *Hospital and Community Psychiatry, 45*, 27–31.

Allen, A. (1988). West Indians. In L. Comas-Diaz & E. E. H. Griffith (Eds.), *Clinical guidelines in cross-cultural mental health* (pp. 303–332). New York: Wiley.

Anda, D. (1984). Bicultural socialization: Factors affecting the minority experience. *Social Work, 29*, 101–107.

Anosike, B. (1982). African and Afro-Americans: The basis for greater understanding and solidarity. *Journal of Negro Education, 51*, 434–448.

Atkinson, D. R. (1983). Ethnic similarity in counseling psychology: A review of research. *The Counseling Psychologist, 11*(3), 79–92.

Atkinson, D. R. et al. (1986). Afro-American preferences for counselor characteristics. *Journal of Counseling Psychology, 33*, 326–330.

Baker, F. M. (1988). Psychiatric treatment of older African Americans. *Hospital and Community Psychiatry, 45*(1), 32–37.

Balkwell, C. et al. (1978). Black and white family patterns in America: Their impact on the expressive aspect of sex-role socialization. *Journal of Marriage and the Family, 40*, 743–747.

Bernal, M. W., & Castro, F. G. (1994). Are clinical psychologists prepared for service and research with ethnic minorities? Report of a decade of progress. *American Psychologist, 49*, 797–805.

Brantley, T. (1983). Racism and its impact in psychotherapy. *American Journal of Psychiatry, 140*, 1605–1608.

Butler, R. O. (1975). Psychotherapy: Implications of a black-consciousness process model. *Psychotherapy: Theory, Research and Practice, 12*, 407–411.

Casimir, G. J., & Morrison, B. J. (1973). Rethinking work with 'multicultural populations.' *Community Mental Health Journal, 29*(6), 547–559.

Comas-Diaz, L., & Jacobsen, F. M. (1991). Ethnocultural transference and countertransference in the therapeutic dyad. *American Journal of Orthopsychiatry, 61*, 392–402.

Cooper, S. (1973). A look at the effect of racism on clinical work. *Social Casework, 54*(2), 76–84.

Cose, E. (1993). *The rage of a privileged class: Why are middle class blacks angry and why should America care?* New York: Harper Collins.

Cross, W. E. (1978). The Cross and Thomas models of psychological nigrescence. *Journal of Black Psychology, 5*, 13–19.

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Dohrenwend, B. P., & Dohrenwend, B. S. (1974). Social and cultural influences on psychopathology. *Annual Review of Psychology, 25*, 417–452.

Dohrenwend, D. B. (1967). Social status, stress, and psychological symptoms. *American Journal of Public Health, 57*, 625–632.

Dreger, R. M., & Miller, K. S. (1968). Comparative psychological studies of negroes and whites in the United States. *Psychological Bulletin, 70*, 1–58.

Fischer, N. (1971). An interracial analysis: Transference and countertransference significance. *American Psychoanalytic Association Journal, 19*, 736–745.

Foulks, E. F., Bland, R. J., & Sherrington, D. (1995). Psychotherapy across cultures. In J. M. Oldham & M. B. Riba (Eds.), *Review of Psychiatry:* (Vol. 14, pp. 511–528). Washington, DC: American Psychiatric Press.

Gazmararian, J. A., James, S. A., & Lepkowski, J. M. (1995). Depression in black and white women. The role of marriage and socioeconomic status. *Annals of Epidemiology, 5*(6), 455–463.

Glazer, N. (1998). *We are all multiculturalists now*. Cambridge, MA: Harvard University Press.

Grier, W. H., & Cobbs, P. M. (1968). *Black rage*. New York: Basic.

Griffith, M. S. (1977). The influences of race on the psychotherapeutic relationship. *Psychiatry, 40*, 27–40.

Griffith, M. S., & Jones, E. E. (1979). Race and psychotherapy: Changing perspectives. *Current Therapies, 16*, 225–235.

Hall, G. C., & Malony, H. H. (1983). Cultural control in psychotherapy with minority clients. *Psychotherapy: Theory, Research and Practice, 20*, 131–141.

Havens, L. L. (1974). The existential use of the self. *American Journal of Psychiatry, 131*(1), 1–10.

Helms, J. E. (1986). Expanding racial identity theory to cover counseling process. *Journal of Counseling Psychology, 33*(1), 62–64.

Hobbs, S. R. (1985). Issues in psychotherapy with black male adolescents in the inner city: A black clinician's perspective. *Journal of Non-White Concerns, 13*, 79–87.

Holmes, D. E. (1992). Race and transference in psychoanalysis and psychotherapy. *International Journal of Psycho-Analysis, 73*, 1–11.

Ibrahim, F. A. (1985). Effective cross-cultural counseling and psychotherapy: A framework. *The Counseling Psychologist, 64*, 134–145.

Jones, A., & Seagull, A. A. (1977). Dimensions of the relationship between the black client and the white therapist: A theoretical overview. *American Psychologist, 32*, 850–855.

Jones, A. C. (1985). Psychological functioning in black Americans: A conceptual guide for use in psychotherapy. *Psychotherapy, 22*(2), 365–369.

Jones, B. et al. (1970). Problems of black psychiatric residents in white training institutions. *American Journal of Psychiatry, 127*(6), 798–803.

Jones, E. E. (1978). Effects of race on psychotherapy process and outcome: An exploratory investigation. *Psychotherapy: Theory, Research and Practice, 15*, 226–236.

Klein, G. S. (1976). *Psychoanalytic theory: An exploration of essentials*. New York: International Universities Press.

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Korchin, S. (1980). Clinical psychology and minority problems. *American Psychologist, 35*, 262–269.

Lander, J. A. (1972). *Tomorrow's tomorrow: The black woman*. Garden City, NY: Anchor.

Littlewood, R., Moorehouse, S., & Acharyya, S. (1992). The cultural specificity of psychotherapy. *British Journal of Psychiatry*, *161*, 574.

Mayo, J. A. (1974). The significance of sociocultural variables in psychiatric treatment of black outpatients. *Comprehensive Psychiatry, 15*, 471–482.

Morrow, R. S. (1975). Introduction: Symposium in ethnic differences in therapeutic relationships. *Professional Psychology, 6*, 470–474.

Morten, F., & Atkinson, D. R. (1983). Minority identity development and preference for counselor race. *Journal of Negro Education, 52*(2), 156–161.

Myers, H. F. (1982). Stress, ethnicity, and social class: A model for research with Black populations. In E. E. Jones & S. J. Korchin (Eds.), *Minority mental health* (pp. 118–148). New York: Praeger.

Neal, A. M., & Wilson, M. L. (1989). The role of skin color and features in the black community: Implications for black women and therapy. *Clinical Psychology Review, 9*, 323–333.

Nobles, W. (1976). Extended self: Rethinking the so-called negro self-concept. *Journal of Black Psychology, 2*, 15–24.

Parham, R. A., & Helms, J. E. (1981). Influence of black students' racial identity attitudes on preference for counselor ethnicity and willingness to use counseling. *Journal of Counseling Psychology, 30*, 258–261.

Parham, R. A., & Helms, J. E. (1985). Relation of racial identity attitudes to self-actualization and affective states of Black students. *Journal of Counseling Psychology, 32*, 431–440.

Pena, J. M., & Koss-Chioino, J. D. (1992). Cultural sensitivity in drug treatment research with African American males. *Drugs and Society, 1–2*, 157–179.

Perry, J., & Cooper, S. (1989). An empirical study of defense mechanisms. *Archives of General Psychiatry, 46*, 442–452.

Pomales, J., Claiborn, C. D., & La Fromboise, T. D. (1986). Effects of black students' racial identity on perceptions of white counselors varying in cultural sensitivity. *Journal of Counseling Psychology, 33*, 57–64.

Rendon, M. (1993). The psychoanalysis of ethnicity and the ethnicity of psychoanalysis I. *The American Journal of Psychoanalysis, 53*(2), 109–122.

Ridley, C. R. (1984). Clinical treatment of the nondisclosing black client: A therapeutic paradox. *American Psychologist, 39*, 1234–1244.

Ridley, C. R., Mendoza, D. W., Kanitz, B. E., Angermeier, L., et al. (1994). Cultural sensitivity in multicultural counseling: A perceptual schema model. *Journal of Counseling Psychology, 41*, 125–136.

Rosen, H., & Frank, J. D. (1962). Negroes in psychotherapy. *American Journal of Psychiatry, 119*, 456–460.

Rozensky, R., & Gomez, M. (1983). Language switching in psychotherapy with bilinguals. *Psychotherapy: Theory, Research and Practice, 20*, 152–160.

Russell, D. (1987). Language and psychotherapy: the influence of non-standard

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English in clinical practice. In L. Comas-Diaz & E. E. H. Griffith (Eds.), *Cross-cultural mental health* (pp. 33–68). New York: Wiley.

Sabshin, M., Diesenhaus, H., & Wilkerson, R. (1970). Dimensions of institutional racism in psychiatry. *American Journal of Psychiatry, 1227*, 787–793.

Sager, C., Brayhoy, T. L., & Waxenberg, B. R. (1972). Black patient–white therapist. *American Journal of Orthopsychiatry, 42*, 415–423.

Sattler, J. M. (1977). The effects of therapist–client racial similarity. In A. S. Burman & A. M. Razin (Eds.), *Effective psychotherapy* (pp. 252–290). New York: Pergamon Press.

Smith, E. J. (1985). Ethnic minorities: Life stress, social support, and mental health issues. *The Counseling Psychologist*, 13, 537–579.

Smith, E. J. (1989). Black racial identity development: Issues and concerns. *The Counseling Psychologist, 17*, 277–288.

Smith, E. J. (1991). Ethnic identity development: Toward the development of a theory within the context of majority/minority status. *Journal of Counseling & Development, 70*, 181–188.

Spurlock, J. (1982). Black Americans in cross-cultural psychiatry. In G. A. Littleton & M. A. J. Wright (Eds.), (pp. 163–178).

Staples, R. (1970). The myth of black matriarchy. *The Black Scholar,1*, 8–16.

Sue, D. W., & Sue, D. (1990). *Counseling the culturally different.* New York: Wiley.

Sue, S. (1977). Community mental health services to minority groups: Some optimism, some pessimism. *American Psychologist, 32*, 616–624.

Sue, S. (1990). Psychotherapeutic services for ethnic minorities: Two decades of research findings. *American Psychologist, 43*, 301–308.

Tesser, A., & Beach, S. R. (1998). Life events, relationship quality, and depression: An investigation of judgement discontinuity *in vivo*. *Journal of Personality and Social Psychology, 74*(1), 36–52.

Thomas, C. (1970). Different strokes for different folks. *Psychology Today, September*, 49–58.

Tyler, F. B., Sussewell, D. R., & Williams-McCoy, J. (1985). Ethnic validity in psychotherapy. *Psychotherapy, 22*, 311–320.

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