THE BLACK AMERICAN AND PSYCHOTHERAPY: THE DILEMMA

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Past research indicates mental health services for Black Americans have been fraught with a variety of problems as a result of racism. Many of the forces which historically estranged blacks and whites permeate the mental health services received by Black Americans. Counseling, psychotherapy, and mental health service delivery outcome research indicate that Black Americans are more likely to receive medication rather than psychotherapy, to be assigned junior rather than senior staff persons for treatment, receive long-term psychotherapy less often, and be diagnosed as having more severe psychopathology. This pattern of racism in mental health has a long historical tradition which still remains embedded in the psychological theories, assessment instruments, and applied methods used to train psychotherapists. This article examines the ethnocentric bases of the history of psychological assessment, theories, and research findings central to the teaching of psychotherapy, within the context of the historical, cultural, and ethnic milieu of the Black American.

Mental Health Models

An increased focus on the mental health needs of the Black American has occurred as a result of the rising numbers of blacks who are being seen in treatment. Much of this interest has developed as a result of the mass ineffectiveness that the profession has experienced in attempting to treat the Black American using its traditional orientations and methods (Jones, 1974; Lorion, 1973, 1974; Mays, 1974*b*; Sue *et al.*, 1974; Thomas & Sillen, 1972; Vontress, 1971; Wolkon *et al.*, 1973; Yamamoto & Goins, 1965; Yamamoto *et al.*, 1968). For many of the minority members involved in the treatment of the Black American, this interest is a serious concern which is focused on the racist and elitist training of mental health professionals, the quality of treatment that is administered, and the aim and covert agenda of mental health treatment (Banks, 1972; Barnes, 1970; Gardner, 1974; Gordon & Green, 1974; Hayes & Banks, 1972; Jones & Jones, 1970; Mays, 1974*b*; Sue *et al.*, 1974). In general this concern reflects an attempt to acknowledge and change the models of institutional white racism which dominate the mental health profession. The term "institutional white racism" is defined for this article as

> the implicit as well as explicit institutionalization of barriers that serve to reduce Black people's access to meaningful participation as equals in all aspects of a group's function. Such structuralization leads to a relative dimunition of the status of Black members as well as to a depreciation of the Black community as a whole, circularly providing justification for the original barriers (Sabshin *et al.*, 1970, p. 87).

This racism exists in psychiatry and psychology and is highlighted in the delivery of mental health services.

Black professionals such as Grier & Cobbs (1968), McGee & Cedric X (Clark) (1974), Nobles (1976), Windham (1976), and many others are concerned that traditional psychotherapy and in general the majority of psychological interventions, programs, and mental health models are based on a Western conceptualization of psychological reality. This conceptualization totally denies the

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sociocultural reality and self-identity developed by the Black American on account of African heritage and skin color.

The main concern of these and other professionals is that treatment models and their resulting psychological realities are of a European-American philosophy. This white European-American model negates the importance of the Black American's psychosocial culture and African influence in the development of a psychological reality and identity. It denies the reality that there are fundamental *differences*, not *deficits*, that contribute to a different state of awareness, psychological reality, and definition of mental health for blacks.

As an example, Nobles (1976) presents his concept of the European and African view of the world (see Table 1). His logic is that a people's world view explains its philosophy of humanity and what is appropriate in everyday functioning. This view results in a definition of mental health.

For the white American much of this philosophy is acceptable as it is derived from a European origin. It reflects the influence of other nations on the development of the American nation and also the assimilation of many European immigrants and their culture into the American mainstream. What white psychology systematically ignores is the exclusion of black ideology from this philosophy. Further, they fail to consider that though slavery and now institutional racism attempt to strip Black Americans of their culture and identity, it is the remnants of African philosophy which help Black Americans to survive and define what black mental health is.

Philosophies that differ from the white norm are seen as representing mental aberration. The result of this intolerance of cultural differences is that the mental health of the Black American is evaluated against a European-American psychological reality. In such a reality the Black American appears as a sick, white-black individual who needs to be "indoctrinated into believing and accepting Western conceptions of reality and its implicit definitions of psychology and mental health" (Nobles, 1976, p. 23).

This promulgation of a white model of mental health has the effect of denying the Black American's ethnic identity. Minority professionals are concerned that treatment and assessment of the Black American take this ethnicity and its philosophical differences into account when attempting to analyze the behavior and reactions of blacks.

Racism in Psychology and Psychiatry

Mental health services, specifically psychotherapy, were made possible for the Black American only in recent years, due to the increase in the number of public mental health clinics and community mental health centers. In its formative years psychotherapy was available for very few blacks. The exceptions usually were those blacks who had been educated and were economically well off. Historically, blacks as a group have been excluded from or segregated in the public mental health facilities. In the late eighteenth and nineteenth centuries blacks in most cases were not accepted in the state mental hospitals, or were either placed in segregated hospitals or kept separately from the rest of the population (Prudhomme & Musto, 1973). If the "colored-section" of these hospitals had no available space, the black patients were either sent to almshouses or placed in jail.

TABLE 1. Comparative World-View Schematic*

European World View		African World View
Individuality	Psychobehavioral modalities	Groupness
Uniqueness		Sameness
Difference		Commonality
Competition	Values and customs	Cooperation
Individual rights		Collective responsibility
		Cooperateness and interdependence
Separateness and independence		
Survival of the fittest	Ethos	Survival of the tribe
Control over nature		One with nature experiential community
Experiential community		

* From Nobles, 1976, p. 24.

In either of these places they received anything but therapeutic treatment.

In the nineteenth century, significantly enough, following the legal abolition of slavery, most "treatment" of the Black American was based in fact on research aimed at highlighting deficits. The author contends that this deficit research played a key social role in that with the legal abolishment of slavery it became crucial to find support for the continuation of slavery and the development of a mechanism of physical control for blacks. It is speculated that many whites were experiencing a state of panic because of the crumbling of the institution of slavery. This crumbling resulted in such emotional turmoil as loss of identity, feelings of powerlessness, insecurity, and anxiety.

As an example of this attempt to sustain slavery, in 1840 the United States government decided to include in its census demography the number of individuals in mental hospitals. This survey produced statistics indicating that there were very few blacks in the South suffering from mental disorders but that as one progressed toward the North the number increased. Psychiatry used these statistics to prove that blacks were "uncivilized" and less emotionally sensitive. The lack of mental disorder on the part of the Southern blacks according to psychiatry pointed to their mental retardation and the redeeming aspects of slavery. These statistics were also used to support the argument that slavery was good for blacks since they indicated that free blacks in the North were becoming mentally ill. Based on such data it was concluded:

> The Black man functions best, psychologically when he stays or is forcibly kept within the limits of his handicap. Unburdened by responsibility, he is cheerful, and happy. Thrust into the competitive arena, he breaks down. Social tasks and privileges that are normal for white men are too stressful for him . . . best interests of both the Black man himself and large society dictate that his psychic impairment be recognized (Thomas & Sillen, 1972, p. 1).

In regard to psychotherapy, the thinking that dominated psychiatry at that time, as evidenced by the above quote, and continues today is that psychotherapy especially in traditional forms is useless with black patients. The medical model, which was the dominant one of this era proclaimed, based on scientific research, that the use of psychotherapy with black patients was useless since their mental disorders were either the result of a genetic deficit or a physiological difference. It was stated:

> The Negroes' brain is smaller, has fewer nerve cells and fibers; the brains' efficiency depends on the number and position of fibers. Therefore, the possibilities of developing the Negro are limited. . . . The Negro likes melody and ostentation, lacks judgment and is incapable of devising hypotheses. We are forced to conclude that it is useless to elevate the Negro by education or otherwise except in the direction of his natural endowments (Bean, 1906, quoted in Thomas & Sillen, 1972, p. 5).

This racism inherent in psychiatry is equally as pervasive in clinical psychology. In its early formation of clinical theory and models of personality development, the deficit model is clearly present. As an example, one can read some of the direct quotations from individuals in psychology, some of whom are considered its founding fathers. The contributions of many of these individuals still exist in the form of schools of psychotherapy or techniques of assessment which are widely practiced today.

> *Galton*—It is in the most unqualified manner that I object to pretensions of natural equality. . . . The mistakes that Negroes made in their own matters were so childish, stupid and simpleton-like, as frequently to make me ashamed of my own species.
>
> *G. Stanley Hall*—Medical treatment of the races is as different as the application of veterinary medicine from horse to oxen (1905).
>
> *William McDougall*—In the great strength of his instinct of submission we have the key to the history of the Negro race (1921).
>
> *Carl G. Jung*—If you study the races as I have done, you can make very interesting discoveries. The different strata of the mind correspond to the history of races. The Negro is probably a whole historical layer less than the white man (1928, 1930).
>
> *Robert Yerkes*—I.Q. tests brought into clear relief . . . the intellectual inferiority of the Negro . . . education alone will not place the Negro on par with its Caucasian competitors (1921).
>
> *Lewis Terman*—Their dullness seems racial. . . . Judged psychologically they cannot be considered normal (1916, quoted in Thomas & Sillen, 1972).

This list could go on and on, and though all these quotes are from 1905 to 1921, the same thinking dominates psychology and psychiatry today but in a more subtle manifestation. Today, the medical model of early times has found itself in competition with a more subtle, "liberal" deficit model which is referred to by such euphemisms as "cultural deprivation," "environmental deprivation," "cultural disadvantage," and "social pathology." As the medical model was primarily aimed at the results of the legal abolishment of

slavery, the cultural deprivation model is aimed at the results of the 1954 *Brown* vs. *Board of Education* decision. It is not by chance that the cultural deprivation model operates primarily within the educational system.

This model purports that the culture or the environment of the Black American is maladjusted and does not adequately prepare the black child for high achievement in school, "appropriate sex-role behaviors," and in general suitable behaviors and ideals which are consistent with an Euro-American middle-class frame of reference (White, 1970).

Some of the assumptions which underlie this model are, again, a negation of the Afro-American subculture and a promulgation of the black inferiority/white superiority philosophy (Johnson, 1969). Within the dimensions of this model many of the early experiences and subsequent behaviors of the black child are labeled as negative, inadequate, and deprived (Johnson, 1969). Such dimensions can only be based on assumptions, and previously inadequate research which characterize the child-rearing practices of blacks as inadequate and lacking because of a "matrifocal" (inappropriately called "matriarchal") and unstable family system. This model assumes that blacks do not have a cognitive style or a language which is capable of adequate expression and effective communication (Johnson, 1969). Rather, since the black child does not mimic the behavior of the white child and incorporate that value system which is held to be superior, then the black child is in need of "socialization programs," "cognitive stimulation," "language development," "behavior modification," and so on (Johnson, 1969).

Because of the tenacity with which white psychologists uphold the Euro-American philosophy there is a tendency to ignore that research and behaviors of blacks which attest to their strengths and abilities. Examples of such assets which Johnson & Wilderson (1969) cite are blacks' "spontaneity, problem-solving ability and creativity which exist and grow even under severe environmental limitations." "The nature and effect of peer collectives" are ignored though they "are the major socializing agent for urban black children." Another area ignored is "the acute social perceptiveness" the blacks develop, in particular, "the cognitive and affective styles which permit the development of extensive nonverbal communication processes" (Johnson & Wilderson, 1969).

It is the concern of the minority professionals that such strengths and assets be recognized and incorporated into a definition of mental health for blacks.

Areas of Institutional Racism in Clinical Psychology and Psychiatry

This subtle racism which is inherent in the medical and cultural models becomes operationalized in various areas of psychology and psychiatry. This racism tends to regulate the dominant psychological reality and affect the attainment and type of mental health service available to the black client.

Psychological assessment. Models of intellectual abilities exemplify one such area. The prevailing though controversial models of intellectual development state that for the most part blacks have lower IQs because of genetic inferiority (Eysenck, 1971; Hernstein, 1971; Jensen, 1967, 1969; Shockley, 1972) or that they score lower on measures of intelligence because of cultural deprivation (Henderson, 1975; Ladner, 1975; Rivers *et al.*, 1975). There is much counter-research to the deficit model of intellectual ability, but as Gordon & Green (1974) point out, it does not receive the notoriety that the work of Jensen and others are given. The effect of models such as these are that they tend to maintain the Black American in an oppressive and powerless position in the system because of the ostracizing effects of the labeling (Henderson, 1975; Ladner, 1975; Mays, 1974*a*; Rivers *et al.*, 1975). They also limit the black child's access to quality education. The black child, because of this intellectual assessment process and its subsequent labels, finds that he or she is relegated to special classes, remedial tutoring and/or enrichment programs such as Project Head Start, Upward Bound, and others. This process on a psychological level perpetuates a negative self-image for the black child (Johnson, 1969), thereby supporting a self-identity which is riddled with feelings of worthlessness and inferiority (Gunnings, 1972).

Though black psychologists have called for a moratorium on testing, the testing movement continues to thrive. Research grants on the question of whether blacks intellectually are genetically inferior or culturally deprived are continually funded. This is understandable when one examines the history and function of the testing movement. Many psychologists, both black and white, in their naiveté accept the history of clinical psychology books which date the beginning of the

testing movement with the classification needs of the Armed Forces in World War I. Quite to the contrary, the testing movement began much earlier with the onset of the freeing of black slaves and the growth of industry and urbanism. Karier (1972) quite adeptly describes the relationship between the testing movement and corporate industry. As to the origins of testing, Karier (1972) makes the following statement:

> The roots of the American testing movement lie deeply embedded in the American progressive temper which combined its belief in progress, its racial attitudes and its faith in the scientific expert working through the state authority to ameliorate and control the evolutionary progress of the race (p. 159).

The testing movement began with the Emancipation and the growth of urbanism which caused both blacks and immigrants to have an impact on industry. A cooperative working relationship developed among labor unions, corporate wealth, and the federal government with the belief that "their best interests were served by the establishment of a regulatory system which eliminated conflicts and stabilized the economic-social system" (Karier, 1970, p. 155). The result was that corporate industry financed those studies which were often translated into public policies which were favorable to the continuation of the foundation and their philosophies.

What the testing movement did, which was and to some extent still is financed by corporate foundations, was to provide a "continuous measurement and accountability tool for the meritocracy." It provided what appeared to be an objective instrument to convince blacks and immigrants of their lower-class position in the social structure. It is not by accident but rather by the design of institutional racism that individuals who were central in the development of intellectual assessment were also some of the strongest advocates for eugenics control. According to Karier (1970) the two movements (testing and eugenics control) often came together in the same individuals under the guise of scientific testing and always found foundation support.

Henry E. Garrett, who chaired Columbia's department of psychology, was past president of APA, and a member of the National Research Council, was quite open in his beliefs of eugenics control. In 1966, he published several pamphlets in which he justified white institutional racism on scientific grounds. Garrett is quoted as saying:

> You can no more mix the two races and maintain the standards of White civilization than you can add 80 (the average I.Q. of Negroes) and 100 (average I.Q. of Whites), divide by two and get 100. What you would get is a race of 90's and it is that 10 per cent differential that spells the difference between a spire and a mud hut; 10 per cent-or-less is the margin of civilization's "profit"; it is the difference between a cultured society and civilization. Therefore it follows, if miscegenation would be bad for White people . . . For if leadership is destroyed, all is destroyed.

As Karier (1970) points out Garrett is doing nothing more than echoing the sentiments of such individuals as Terman, Yerkes, and Thorndike. Today these sentiments are kept alive by Eysenck, Jensen, and Shockley.

Thus, although blacks have a legal right based on the *Brown* vs. *Board of Education* decision to go to any school, testing has provided a means, within schools, to isolate blacks and to deny them quality education, stating that they are unable to benefit from it to the degree whites can (Gordon & Green, 1974).

Diagnosis and social class differences. In the area of actual delivery of mental health services to blacks, racism and classism become operationalized through diagnostic procedures that determine who receives treatment, how long, and what kind.

The differential treatment in the area of diagnosis that occurs in reaction to race is exemplified in the results of the Gross & Herbert (1969) study. With a sample of 2,279 emergency room consultations, it was found that blacks were more likely to be either discharged immediately or hospitalized because of unfavorable prognosis. White individuals in this study were found likely to be referred for outpatient psychotherapy with good prognosis for treatment and recovery.

Various other studies (Baughman, 1971; Haase, 1964; Kramer *et al.*, 1973) have shown that lower-class and/or black individuals are more likely to be diagnosed as psychotic rather than neurotic. As an example, Shapiro (1975) states that whites are more likely to be diagnosed as having repressive psychosis while blacks will be labeled as schizophrenics because psychiatrists in the past were taught that black people do not suffer from depression. As is the case even when whites are diagnosed as schizophrenics they are usually subdiagnosed as reactive types which gives them a good prognosis for recovery and enhances their chances for psychotherapy. Blacks are typically subdiagnosed as process or chronic schizophrenics, which implies a poor prognosis.

In the case of blacks, especially black male patients, schizophrenia (paranoid type) has a dis-

proportionately high rate as a diagnosis. This diagnosis usually results from seeing as pathological the suspiciousness and distrust that may in fact be a reality-oriented perspective for the Black American. Grier & Cobbs (1968) make it quite clear that such behavior is an adaptive method for coping with the oppression and racism of the social system, and must be judged as such. Such diagnosis reflects the conscious and unconscious attitudes of psychiatry and psychology today (Shapiro, 1975).

There has been a surge of studies showing the relationship between social class and treatment. A correlation consistently exists between an individual's socioeconomic status and his or her acceptance for and duration of treatment (Bailey *et al.*, 1959; Brill & Storrow, 1960; Cole *et al.*, 1962; Heitler, 1976; Hollingshead & Redlich, 1958; Jones, 1974; Lorion, 1973, 1974; Pettit *et al.*, 1974; Schaffer & Myers, 1954; Siassi & Messer, 1976; Wolkon *et al.*, 1973). Further, the attrition rates tend to be higher and the length of treatment shorter when the therapist views a patient negatively or has middle-class expectations (Afflect & Garfield, 1961; Baum *et al.*, 1966; Goldstein, 1960*a*, *b*, 1962*a*, *b*, 1966*a*, *b*) which typically is the case with a white therapist and a black client from a lower socioeconomic-status background.

Racial and cultural factors in treatment. As we move from social class to race, similar issues remain. Hollingshead and Redlich (1953) concluded that there was a definite interaction between race and the type of treatment received by blacks. They found that blacks were more likely to receive either custodial care or electroconvulsive shock therapy than psychotherapy or drugs. The higher incidence of electroshock therapy for blacks than for whites is also supported by Masserman (1960).

Jackson (1976) cites two studies which identify some of the more subtle instances of racism in therapy. The first is a study by Adams (1950) in which it was found that with black clients the issue of race was either totally avoided or the therapists were oversympathetic. Adams speculated that these tendencies along with those of being indulgent, hostile, or patronizing were the result of the therapist's lack of knowledge and savvy with blacks and/or an ambivalence about working with black clients. There is little doubt that such feelings on the part of the therapist could have been important factors in precipitating early terminations.

The other study done by Brill & Storrow (1960) established that blacks were less often accepted for treatment or were assigned therapists who were less experienced. Lerner (1972) and Sue *et al.*, (1974) also cited the fact that blacks were more likely to be seen by inexperienced and paraprofessional staff than whites.

When the therapist differed from the client in both race and social class it was found that the level of self-exploration in the initial interviews were lower (Carkhuff & Pierce, 1967). Wolkon *et al.* (1973) found race to be a more important factor than social class in influencing the level of self-disclosure. In studies in which both the therapist and the client are black the results are inconclusive, although they definitely indicate that race is an important factor. English (1957) felt that black clients were so conscious of their minority status that they were unable to express their feelings to other blacks in the counseling setting. Calnek (1970) states that either overidentification or a denial of identification on the part of a black therapist with black clients is detrimental to the continuation and success of the psychotherapy. On the other hand, Banks *et al.*, (1967) and Phillips (1960) both found that blacks were more amenable to self-disclosure if the therapist were black.

In the Wolkon *et al.* (1973) study, in which race was found to be more important than social class in the level of self-disclosure, it was noted that both race and social class together were related to the client's attitude toward psychotherapy. On the issue of self-disclosure this study did not find any class differences among blacks. Rather, it supported previous research (Jourard & Lasakow, 1958; Kadushan, 1969) that self-disclosure is associated more than race or class socialization.

On the issue of the relationship of social class to orientation to help-seeking, the Wolkon *et al.* (1973) study found that middle-class blacks were more positive in seeking help.

Therefore it can be seen that the issues of race, social class, and diagnosis interrelate in a complex manner in affecting the type, length, and availability of psychotherapy for the black client. Given the middle-class biases, the social-class differences, and the stereotyped thinking of white professionals, access to *continued* treatment becomes difficult for the Black American. Gardiner (1971) makes the point that white therapists, in seeing black patients, carry into the hour many attitudes, expectations, and stereotypes that have been derived from reading the racist psychological literature. This, reinforced by conscious and unconscious

attitudes about blacks on the part of the therapist, supervisors, professors, etc., decrease the likelihood of effective psychotherapy for the Black American.

Therefore in the context of psychotherapy, the question is often posed whether to use clinical theory and technique as it stands or whether a new model is needed in treating the Black American. Flower (1971), Friedman (1966), Heitler (1976), Hunt (1960), and Riessman (1962) support the notion that theory and/or clinical technique at present are not appropriate for the black client. Riessman *et al.* (1964) recommend that one ignore theory as it stands and seek support elsewhere. Waite (1968), on the other hand, supports using clinical theory as it stands. What most of these authors are saying in differing degrees is that some type of adaptation is necessary. Friedman (1966), for example, used James Baldwin's theories to make interventions and interpretations in the therapy of a black female client.

Psychocultural Differences of the Black American

The question of whether to abandon theory or adhere to it is a crucial one in the psychotherapy of the Black American though it represents only a minuscule part of the solution. The psychotherapist who is racist and/or ignorant of either his or her own cultural conditioning or that of the client is going to be ineffective as a therapist regardless of the model. The lack of such knowledge makes it extremely difficult if not impossible for the therapist to be empathic and genuine in the therapeutic relationship (Vontress, 1970). What the studies cited above seem to imply is that there is a definite need for an increase in minority professionals who can define black mental health and black mental illness. But until that happens there is a need for an education on the part of white professionals as to the cultural differences, not deficits, of the Black American so that adequate service may be provided to black clients.

Blacks as a group bring to therapy many extraneous variables and defenses which are radically different from those of members of other groups. For the Black American, experiences of degradation, humiliation, and oppression are often experiences which are fused with reality. For whites such experiences often reside only on a fantasy level, as society is set up to protect the white individual from such experiences (Grier & Cobbs, 1968). The clinician's task in pointing out fantasy from reality is therefore oftentimes more difficult with the black client. The black client may tend to attribute everything to racism and find it difficult to understand his or her own behavior. On the other hand blacks may be equally determined not to see any racism and to blame themselves for everything, rather than experience the hurt of racism.

Therapy for the black client may at times seem frustrating and useless. As changes are accomplished internally the black client finds it difficult if not impossible to change the world he or she lives in. The therapy has served to bring about an increased awareness of the oppression and powerlessness the black client must struggle against in the system, and this is a harsh reality. This often leads both the therapist and the client toward questioning the validity and usefulness of an increased awareness when social change is so difficult. According to Grier & Cobbs (1968):

> A Black man's soul can live only if it is oriented toward a change of the social order. A good therapist helps a man change his inner life so that he can effectively change his outer world (p. 180).

The process of slavery and its debilitating effects on the development of self-identity imposed on the Black American present a unique psychological development which is not comparable with any other group lacking such an experience. Blacks were brought to this country, forcibly cut off from the past, and robbed of language and culture. They were not allowed to remain African or become American (Grier & Cobbs, 1968). This gave rise to feelings of separateness and alienation not experienced by other groups who laid claim to land and became integrated into the American mainstream. Much of the difficulties and differences in the Black American derive from this history of bondage as the experiences of slavery were passed from generation to generation as character traits, traditions, and rules of survival. At the same time this adjustment was consistent with the philosophical traditions and cultural mores of an African people as this was the heritage of the early slaves.

One of the psychobehavioral modalities in Table 1 which was and still is important in analyzing the behavior and drawing up a treatment model for blacks is that blacks are tribally oriented. Blacks as a group are more invested in a survival of the group than of the fittest. Within this, values of cooperativeness, collective responsibility, and

cooperation are more valued than competitiveness and independence which are characteristic of a Euro-American philosophy.

However, the present models of treatment and psychological interventions are aimed more at individual psychology. The community mental health centers, for example, find it difficult to do traditional family therapy because they lack an understanding of the phenomenon of "community" among Black Americans. The family therapist finds it difficult to understand why Aunt Bessie who is not really an aunt can discipline the kids and participate in family arguments. It is a sense of community and collective responsibility which brings about this type of behavior.

This value system in turn has given rise to a different type of family structure in the black community. The black family is a tribal family (Nobles, 1974) or an extended family (Billingsley). This type of structure includes Aunt Bessie and several others who are not related genetically. This difference in structure, purpose, and function causes alternative relationship bonds to develop, all of which contribute to the development of an individual's self-identity. A model of mental health needs to be cognizant of these distinctions.

The language of the Black American reflects many of the remnants of African tradition. Blacks are primarily oral in their orientation. The language and the process of communication psychologically are rich with dynamics that reflect the black experience. White (1970) suggests that psychologists need to examine these oral expressions to better understand the psychological functioning of Black people. In the actual treatment setting this difference is manifested by the "sounding" or the emotionality in which blacks engage, which is often interpreted as hostility, anger, and acting-out.

These are just some of the factors that contribute to the Black American's identity development and concept of mental health. The dynamics of the psychological development of the Black American are both historical and social in nature. Any type of psychological intervention or model of treatment needs to incorporate these factors if it is to be effective in promoting psychological well-being in Black Americans.

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