Evidence-Based Practices and African American Clients

LaVerne Hanes Stevens, PhD, and Janet C. Titus, PhD

EVIDENCE-BASED PRACTICES (EBP), INCLUDING BOTH evidence-based assessments and interventions, are intended to ensure that clients receive services that have scientific proof of their effectiveness. The push toward EBP has precipitated the question of whether they can adequately address the unique issues of race, ethnicity, sexual orientation, disability status and regional distinctions (Sue & Zane, 2006). This article offers a candid discussion of some concerns related to EBP for African-American professionals, families and clients, as well as some recommendations for substance abuse treatment professionals.

In the African-American treatment community, the dividing line between providers in response to EBP is often drawn based on the providers' training grounds—academic learning versus experiential learning. In the recovery community in general and in the African-American recovery community in particular, counselors from within the recovery ranks carried the treatment-provider system for decades. Many worked in inner cities and low-income areas where few others dared to go. As EBP increasingly became the gold standard of substance abuse treatment, questions from the homespun experiential recovery community arose. Offense was often caused by the suggestion that "treatment as usual" was not effective. Concerns were raised about whether manualized

EBPs, usually developed primarily by people representative of other ethnic cultures, could do a better job at rehabilitating African Americans than the historically invested counselors who often shared the experience of being black and addicted.

Alex Brumbaugh (2010), noted advocate in nonconventional treatment modalities, speaks sharply against any indiscriminate acceptance of EBP and even criticizes "... medicine, psychology, scientific research, and the criminal justice system for coming late to the party and now wanting to take it completely over." Like Brumbaugh, many counselors have either critically questioned or simply rejected the efficacy of EBP for assessment and treatment of culturally diverse groups. As we suggested in our prior article, this is attributable, in part, to anecdotal and empirical findings about disparities in diagnoses, treatment and placement of African Americans when using EBP (Hanes-Stevens & Titus, 2011) as well as the perception that African Americans have been minimally represented in the research on which EBPs are based (Sue & Zane).

Despite endorsement of the need for cultural competence in the field from both the academic community and professional organizations, there is still hesitation on the part of many minority providers and clients to trust that an EBP will not perpetuate treatment disparities further. So, at one end there is a community in support of EBPs and empirically supported treatment. On the other end, there are those who dismiss EBPs as culturally insensitive and advocate for "treatment as usual." Which way will the African-American treatment vote swing when it comes to EBP?

The answer to that question largely depends on how well advocates of EBP are able to recognize the cultural factors that can affect an African-American's response to EBP. This requires a contextual and historical awareness from intake through discharge at every point in the continuum of care.

How Can EBP Effectively Address the Various Dimensions of Client Diversity?

The question of cultural sensitivity with EBP was recently brought to subject experts, trainers and treatment providers from diverse backgrounds who came together for two and one-half days of discussions about cultural adaptations and implications when using the GAIN (Global Appraisal of Individual Needs). The GAIN is an evidence-based family of assessments used widely in the substance abuse treatment field in both the United States and Canada. Participants in the GAIN Cultural Sensitivity Summit—sponsored by SAMHSA's (Substance Abuse and Mental Health Services Administration) Center for Substance Abuse Treatment (CSAT)—worked together to answer the following question: "How can an evidence-based assessment like the GAIN most effectively address the various dimensions of diversity of clients with substance use disorders?" As described in the original article in this series, the summit participants identified the following five user competencies as being essential:

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- Recognize the power of historical perspective
- Appreciate the impact of cultural explanations and stigmas
- Respect cultural variations, expectations and communication
- Create an atmosphere of cultural safety
- Show adaptability and flexibility

In part two of this six-part series on lessons learned from the GAIN Cultural Sensitivity Summit, we continue with the discussion started in the August 2011 *Counselor* feature article by summarizing the main points for effectively using EBP with African-American clients.

How Can EBP Be Used Effectively with African-American Clients?

Recognize the power of historical perspective.

A well-trained clinician recognizes the importance of every client's unique, individual story. However, when serving clients of an ethnic, social or cultural community different from their own, there is also a "collective story" that may be unknown or overlooked by the clinician (McGoldrick, 1998; Paniagua, 2005). That history—and its effect—is just as salient and powerful as the client's individual story. The difference is that the collective history cannot always be verbalized by the client but is ever present and impacts the client and the therapeutic relationship. Whether or not the cultural story can be expressed by the client, the clinician must be cognizant that the collective story may have influenced and shaped the client's values, fears and relationships just as much as the client's personal story.

The collective experience of people of African descent in the United States has been scarred by at least 300 years of segregation, marginalization, discrimination, systemic exploitation and violence. The effects of this collective history are still felt in the

African-American community five and six generations removed from the firsthand experience of slavery and Jim Crow laws. In addition, early psychiatry directly contributed to discrimination by prescribing beatings as a way to manage slaves who attempted to run away, supporting theories about racial supremacy and deeming slaves diagnosable as mentally ill if they fought for their freedom. This history reflects a treatment system that often had a strong socioeconomic/political agenda at the expense of African Americans and understandably caused the African-American community to have little trust in the mental health treatment system.

Given this history of African-American sociopolitical abuse and powerlessness, some providers believe African-American clients may respond better when the assessment and interventions come from a strengths- and support-based model rather than from a deficit model. For example, Glide Memorial United Methodist Church in San Francisco has developed a culturally sensitive, strengths-based recovery model with African Americans and other culturally distinct populations in mind (Harley, 2005). Rather than the traditional 12 steps, this model has 11 steps called the Terms of Faith and Resistance. Instead of making a declaration of "powerlessness" as the first step, this model begins with a different step: "To gain control over my life." Harley says that for members of cultural groups that are already at a political, economic and/or educational disadvantage, the declaration of powerlessness "can prove to be more disempowering than empowering and more victimizing than liberating" (p. 126).

Summit participants emphasized the value of strengths-based items that are included in the GAIN. Traditional diagnostic codes are typically deficit-based, and most assessments are designed to measure problems. To prevent the assessment and treatment planning experience from being demoralizing for the client, the clinician may need to be especially attuned to the items in the GAIN that are designed to directly assess the presence of factors such as the client's treatment motivation, social-spiritual supports, perceived personal strengths and reasons for change. When incorporated into clinical planning and referral recommendations, these areas may help to strengthen the client's resolve and treatment engagement. Empowerment can further be strengthened by using the feedback and interpretation process itself as an opportunity to help the client make informed choices. And although hardships are never inherently joyous, in the African-American community an individual's very *survival* through extreme hardship is an opportunity for celebration and for recognition of resiliency skills at the individual and community levels.

In the African-American community, the history of sociopolitical powerlessness has contributed to a rich oral tradition (originating from the prohibition of slave literacy), a prominent role for religion and spirituality (the struggle for liberation) and a broader definition of family. The historically large percentage of single-parent families—with its roots in the slave trade's separation of families, the raping of female slaves, welfare disincentives and the disproportionate incarceration

of African-American males—has resulted in a culture where matriarchal figures are particularly important. Additionally, the definition of family is fluid and may include individuals who are outside of the immediate family or who are not biologically related at all. These are important considerations for involving others, such as surrogate moms and dads, "adopted" aunts, uncles, and cousins, and ministers and mentors in treatment planning. Summit participants specifically noted that the role of grandmothers in the African-American community has been historically quite significant, as grandmothers and great-grandmothers are often the primary caregivers or influencers of children and adolescents. Any therapeutic practice that does not allow for a broad definition of family will likely do a disservice to the client and potentially create a barrier in the therapeutic relationship.

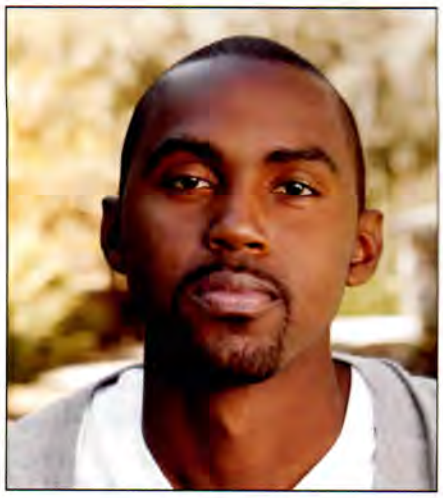
Appreciate the impact of cultural explanations and stigmas.

Stigma related to mental health or substance use disorders is widespread in American culture at large, and even more so in the African-American community where such an admission connotes yet another weakness or vulnerability in a world where people of color have already had to fight against the odds. In some historically African-American religious traditions, mental health and substance abuse problems are addressed primarily from a spiritual perspective. As a result, religious interventions may be more readily accepted than biopsychosocial interventions. At a minimum, treatment providers may do well to address addiction as a biopsychosocial-*spiritual* disorder in such cases.

The African-American community has historically had a higher tolerance for alcohol and other drug problems than for mental illness. Summit participants noted that African Americans typically present for substance abuse treatment at later stages and with greater severity in their addiction symptoms because the African-American community has—by necessity of surviving social injustice—developed a high tolerance for pain and inconvenience. As a result, family members and concerned persons are slower to intervene or request treatment referrals because no matter what challenges the substance abuser presents for those family members, the expectation is that they can "handle it." Particularly, with African-American adolescents, it is most typically juvenile justice intervention that leads to a referral for treatment rather than a family intervention. This referral trend is often interpreted as a systemic bias but, in part, may be attributable to family hesitation to pursue treatment early in the disease process, before legal consequences are imposed.

In the African-American community, the stigma associated with mental health problems has historically been expressed indirectly, rather than directly, through the use of euphemisms such as being "touched," "off her rocker," "not right" or having "bad nerves." A client or family member whose culture tends to stigmatize mental health problems might deny those problems out of fear, resulting in underreporting by the client and their loved ones. If the treatment professional has collateral information strong enough to suggest underreporting, or if responses to an assessment like the GAIN suggest the presence of symptoms that the client does not endorse, the treatment professional should use their clinical judgment in diagnosing or making referrals.

Consider the following case example. "James" was an 18-year-old African-American male with a history of prescription drug abuse along with co-occurring depression and a provisional diagnosis of schizophrenia. James was referred for outpatient counseling upon discharge from the hospital after a suicide attempt and major depressive episode. James



believed that acknowledging his mental illness was a sign of weakness; this view was also supported by his father. James and his family failed to tell the counselors there was a family history of schizophrenia. Even upon James' second suicide attempt, his father was afraid that James would never forgive the family for initiating an involuntary hospitalization. James remained noncompliant with treatment and medication, but eventually his mother and father accepted the counselor's recommendation for the two of them to get supportive counseling and family education to help them understand and accept their son's illness and learn to invest in their own self-care.

The summit participants emphasized that many of the culturally rooted explanations for mental health and substance use disorders are firmly rooted in the everyday sociocultural reality of community members. In the African-American community, poverty has historically been widespread; life situations associated with poverty, such as malnutrition, can be confused with symptoms of ADHD or anorexia. The "healthy paranoia" that African-American parents teach their children as being necessary for success and survival (i.e., the need to "watch your back" at all times) may be misinterpreted as opposition or schizophrenia by an unknowing clinician.

All of these examples underline the importance of cultural awareness among noncommunity clinicians. A lack of understanding can lead to overdiagnosis, underdiagnosis or misdiagnosis of the client's problems during the assessment. Moreover, insensitivity can create a barrier that results in failed treatment and early withdrawal.

Respect cultural variations in communication, expectations, and norms and values.

Summit participants stressed that clinicians of a different culture should be genuine in their communication styles. Barriers are created when clinicians try to "talk black" in a strained attempt to build a therapeutic alliance. The strongest alliances are built around authenticity. Another communication point for clinicians to consider is that if they and the client are from different ethnic backgrounds, the clinician should be comfortable broaching the subject of race in the context of the counseling relationship. This can take the form of an acknowledgment that the client's cultural experience has been different from theirs and asking the client how that might affect treatment, or asking the client to help the clinician become more knowledgeable about the impact of race on the client's experience. All of this must be experienced by the client as authentic and not contrived.

In African-American families, parental roles are largely authoritarian, and the parents of adolescent clients may expect that the clinician should align with the parents' "side" rather than the adolescent's. Clinicians from other backgrounds may be unaware of expectations like these and find that a minimal or standard explanation of client confidentiality may cause problems for the client and the family. Parents may also expect full disclosure and believe that their parental role overrides the adolescent's right to confidentiality. Practitioners doing an assessment or providing treatment services should be aware that client confidentiality might be misinterpreted or seen as suspect by parents. This could result in a lack of parental trust of the treatment provider and withdrawal of the adolescent from treatment.

For example, the mother of the client named "James" became exasperated because treatment providers would not disclose information she wanted about his diagnosis and treatment. Baffled by the confidentiality of the client-counselor relationship, she complained to his counselor, "Even though he is 18, I am his mother and he is my responsibility. No one will tell me anything, so what am I supposed to do?" It is imperative, therefore, to try to help parents and other concerned persons understand the boundaries and rules of the counseling relationship from the beginning. At the same time, however, involving parents and extended family in appropriate ways such as family night or family therapy—with clear expectations about the counselor-client relationship—will often prevent misinterpretation and early treatment withdrawal.

Create an atmosphere of cultural safety.

Providers, especially of a different race or ethnicity than that of the client, may be seen as an extension of an oppressive and unfriendly system, one that does not want the African American to make gainful strides in society. When conducting assessments or providing treatment, clinicians should recognize the possibility of the clients' initial suspicion or mistrust of provider systems due to recent or historic discrimination or maltreatment from government systems. A healthy mistrust of anyone representing the system, especially when working with clients who have had low-income or limited-opportunity backgrounds, is to be expected and even respected. Treatment professionals will need to focus from the very start on establishing trust. Trust cannot be gained immediately, but it will be strengthened as the practitioner demonstrates that she does not intend to force her beliefs on the client nor push the client into any type of unwelcome assimilation or service.

The issue of trust is not just a problem limited to cross-cultural counseling relationships. Trust can be problematic when a treatment professional—even from the same culture as the client—is viewed as a representative of an unfriendly system rather than an advocate for the client's interest. One African-American summit participant who provided in-home services was met with significant resistance by the client's guardian/grandmother. To break down the resistance, the clinician talked informally with the grandmother until finding a shared interest. Upon identifying a common interest, which was a shared religious affiliation, the clinician was successful in engaging the family in services. In fact, the therapist later discovered that the very source of the family's resistance was the family's religious beliefs being judged or undermined in the therapeutic process. When the counselor gently allayed the grandmother's fears about the family's religious beliefs being judged, the therapist was then able to serve the adolescent and his family for months, with the full support of the client's grandmother. This was only possible because the therapist was intentional about building trust. Of course, even if the client and clinician had not shared the same spiritual views, the clinician would have engaged the client and family only if he was able to assure the family that their faith would not be dismissed or maligned.

Show adaptability and flexibility.

In low-income African-American communities, the local programs may lack funds to support prosocial activities (such as buying sports equipment or establishing community playgrounds). This may require the creation of treatment programs that develop prosocial activities and plan for recovery support

systems. For example, one private outpatient program developed its own therapeutic summer day camp program to give youth clients in nearby underresourced communities an option for daily prosocial activities. Youth with behavioral health diagnoses received the benefit of intensive outpatient groups and diverse enrichment activities despite the lack of prosocial activities in the wider community.

Conclusion

Just as clinicians are trained to honor resistance from clients, honoring resistance to EBP shows respect for different viewpoints and different values. If treatment professionals will recognize the power of the African American historical perspective; appreciate the impact of cultural explanations and stigmas; respect cultural variations, expectations and communication; create an atmosphere of cultural safety; and show adaptability and flexibility—then the effectiveness of any EBP will be greatly enhanced. The implication for EBP is paradoxical. The way to win the argument is to refuse to argue. Rather than trying to "win the African American vote," treatment professionals and researchers would do well to balance cultural sensitivity with methodological rigor. When an understanding of the historical and present perspective of African Americans is present, everyone wins.

Acknowledgments

The development of this paper was supported by the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA) contract 270-07-0191. The opinions are those of the authors and do not reflect official positions of the government.

Special thanks to everyone who participated in the GAIN Cultural Sensitivity Summit and the African-American workgroup for their time and invaluable contributions to this paper.

***LaVerne Hanes Stevens, PhD**, is a GAIN senior clinical trainer and product developer at the GAIN Coordinating Center of Chestnut Health Systems in Normal, Illinois.*

***Janet C. Titus, PhD**, is a research psychologist at the GAIN Coordinating Center of Chestnut Hill Health Systems in Normal, Illinois.*

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