A Relational Approach to Clinical Practice with African-American Clients

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Introduction

This chapter examines the use of a relational approach to clinical social work practice with African-Americans (DeYoung 2003; Goldstein et al. 2009). Relational social work holds promise for delivering services in a manner that can rebuild trust in the use of formal treatment services (Fontes 2008; Parham 2002; Sanchez-Hucles 2000; Washington 2006). By affirming difficult realities and daily struggles as well as individual suffering (Hopps et al. 1995; Brown and Keith 2003; Germain 1979; Leary 2005), relational theory places social work clinicians in a uniquely applicable position to practice with African-American clients in a way that unifies cultural relevance with clinical expertise.

The term "African-Americans" is used here interchangeably with the term "Blacks" and refers to persons living in the United States who have origins in any of the Black racial groups of Africa (United States Department of Commerce 2007). African-American clients represent a major component of the overall population in the United States who seek clinical social work treatment services. While these clients may share a common racial history, they also reflect vast differences in terms of their individual cultural heritages.

A wealth of literature already describes strategies for increasing the efficacy of service delivery to African-American clients (Altman 2011; Boyd-Franklin 2003; Devore 1991; Green 1982; Harper-Dorton 2007; Johnson 2005; Jones 1991; Locke 1992; Pinderhuges 1989; Sue 2008). Based on the principle of understanding the client's culture as an integrated component of the biopsychosocial assessment

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process, such emphasis on preconditions of culturally competent work requires extension throughout the clinical process. A relational social work approach is complementary: it builds on assessment to provide principles of attunement with unique issues that arise in work with African-American clients.

Many of the historical, social, and political factors that have had an impact on the lives of African-Americans are described. This is followed by a discussion of how African-Americans utilize treatment services to address their mental health needs. The final section uses case illustrations to demonstrate the therapeutic value and impact of using a relational approach to clinical social work practice with African-American clients. It also emphasizes the importance for the social worker to possess a capacity for self-reflection and for genuine empathy as essential ingredients for engaging in relational social work practice.

Understanding the Socio-cultural, Political, and Historical Contexts of African-American Clients

African-Americans are members of a distinct and internally diverse group who share a common history, out of which arises a common vulnerability to social stereotypes. A working knowledge of the historical and contemporary context of persons who identify as African-Americans is critical to clinicians of all races and ethnicities. There are also African-American clinicians with limited personal and professional interactions with other African-Americans whose day-to-day lives are circumscribed by the isolation of poverty and limited access to resources of all types including financial, emotional, and physical (Payne 1996; Pinderhughes 1997). This illustrates the value emphasized in relational theory's approach of using dialogue to support the creation of a codiscovery process between the client and the clinician. This interpersonal authenticity allows client and clinician to fill in gaps of what is yet unknown about the client and the situation, including the multiple meanings of race that apply to African-Americans. Factual understanding of the historical precursors and social composition of African-Americans as a population group will help the relational clinician establish mutuality: authentic not-knowing does not endorse clinician neglect of efforts to gain familiarity with a client's points of reference and world view. An introduction to some key issues is given below.

Complexity, Confusion, and Misunderstanding of What Race Means

Race has been used as political, biological, and social constructs to characterize the differences that exist between groups of people. The focus here will be on race as a social construct, emphasizing how race frames the experiences and perceptions of individuals who identify as African-American and those who interact with them.

According to Hardy (1994), few issues are as "value laden and misunderstood as is race" (p. 5). Taylor (1997) has suggested that the biological dimension of race (Mongoloid, Negroid, Caucasoid, etc.) is invalid as a scientific concept. Reviewing the more than 50 years of research, Taylor (1997) concluded that "…there is no legitimate biological basis for sorting individuals into groups that correspond to races as they are popularly perceived" (p. 279). Taylor (1997) further noted that the recent attempt to correlate race with intelligence (Herrnstein & Murray 1994), with the call to discard the term "race" altogether, is countered by the importance of retaining race as a construct that reflects the "true nature and significance of human diversity" (p. 279). The relational social worker would concur with this last position: obfuscation or denial of individual dimensions of internal and interpersonal experience runs counter to empathic attunement to social work clients' direct experiences.

Taylor (1997) cites Lopez (1996) and Lee (1993) regarding the 1790 United States Census Bureau development of a racial classification system based on political motivations to maintain racial purity during this period of United States' history. The Census Bureau took responsibility for assigning a person's race, based on family heritage and perceived skin color, with the possible choices being White or non-White. The 1890 census included only one category for White and at least seven categories for non-White. To be White meant legal entitlement to the full range of rights and privileges of citizenship, to which non-Whites were not entitled (Taylor 1997, p. 282). In 1977, the United States Office of Management and Budget (OMB) created four race categories (White, Black, Asian, and Pacific Islander), along with two ethnic categories (Hispanic origin and non-Hispanic origin), and prohibited the term non-White (Taylor 1997). This elimination of non-White as a total population did not end the debate about the significance of categorizing individuals based on their heritage. Omi and Winant (1986) introduced the term "racial formation" to underscore how race has become a "*central axis* of social relations which cannot be subsumed under or reduced to some broader category or conception" (p. 15). The clinical social worker and her clients, each impacted by racial formation, cannot ignore its impact, conscious or unconscious, in their interpersonal encounters.

Impact of "Racial Formation" on Relational Social Work Practice

Racial formation has created a hierarchy of privilege irrespective of how racial categories are defined and redefined. Increasing ambiguity about a person's position in the social hierarchy based on appearance opens a door to exploration rather than assumption, with both client and clinician benefiting from this need to pursue co-constructed meanings of their individual perspective and experience. To proceed otherwise invites false countertransference enactments. As an example, John Hope Franklin, an internationally acclaimed African-American scholar, who upon the occasion of celebrating his receipt of the Presidential Mental of Freedom in 1995, hosted a party during which a White guest who was attending at different event at the

same exclusive club asked him to get her coat. He politely told the woman that any of the uniformed attendants on duty could assist her (Associated Press 2009). Franklin himself being a darker-skinned African-American, and wearing a tuxedo, had provoked the woman to make a social assumption that vividly demonstrated the persistence of the process of racial formation even among the presumably educated.

A case study by Greene (1997) provides another opportunity to consider the process of racial formation from a clinical perspective. A 37-year-old African-American woman entered therapy because she had been bypassed a third time for a promotion in her law firm, in spite of impeccable credentials and outstanding evaluations. The client's belief was that she had faced unfair discrimination, resulting in severe emotional stress. The clinician used the relational approach of co-constructed understanding of meanings to identify the internal and external sources of distress and dysfunction. She struck a balance between overemphasizing or underemphasizing the impact of racial discrimination. Yes, she had faced discrimination, and yes, she realized that staying and continuing to try for promotion in a prejudiced environment would not result in the outcome she sought. At the same time, the clinician guided the client to address deep-seated emotional issues about striving and success in her family of origin, which required denial of a no-win situation and insistence that if she worked hard enough, it would eventually pay off.

This fusion of internal and external exploration sprang from a relational perspective in which the clinical social worker validated reality conditions without abandonment of intrapsychic inquiry. The client eventually left the firm for another position in which her talents and experiences were recognized and valued. When this case was presented to a group of clinical students, there was general disbelief that the client, given her credentials, could *really* (my emphasis) be a "victim of discrimination" (Greene 1997, p. 318). While it may have been contradictory to the conscious values of these clinicians to practice racial discrimination, the teaching point was that they as clinicians could not afford to have their own disappointment and disbelief be used to minimize, refute, or deny the client's experience. In this way, Greene illustrated the central relational theory principle of empathic understanding of the client's interpretation of the problem; this had to precede exploring further dimensions in the treatment process. The social work practitioner's obligation to examine transference and countertransference elements was clarified by Geene's eliciting of the training participants' difficulty validating the client's experience.

The educational preparation of social work clinicians, both clinicians of color as well as white clinicians, requires the adoption of a commitment to include the study and understanding of race, racism, and the social construction of race in the academic curriculum (Basham 1997, 2004). Particularly for the clinical social work student, a basic requirement is to adopt a relational theory perspective that entails critical thinking about the dynamics of dominance and subordination in the delivery of clinical services. Not limited to study *about* populations of diversity, the relational clinical student must process self-reflection for true mutuality in engagement, treatment planning, addressing resistance, transference and countertransference, and co-construction of meanings.

Deconstructing Assumptions/Misconceptions About-African Americans as a Group

A clinical social worker must be prepared to engage African-American clients whose identities include multiple social group memberships, including gender, sexual orientation, and religion, and are rural, urban, and of every social class. In the United States, 12.8 % of households identify as Black (U.S. Department of Commerce 2007). Since this number includes people who identify Black as their only race or Black in combination with other races, being of both Black and White or Black and Hispanic, disparities, social complexities, and psychological dilemmas are baseline expectations (Wijeyesinghe and Jackson 2001). Besides the interpersonal experiences of living in a racially conflicted society, African-American clients of public social service clinicians are apt to represent that portion of the population with economic and social stressors: in the aggregate, Blacks have double or triple unemployment rates, half the income, and three times as many single-mother households (United Stated Department of Commerce 2007). At the same time, it is damaging to assume that every African-American client is living in scarcity or deficit: because middle and upper class Blacks may also be clients. The relational theory position of inquiry rather than assumption guides the social work clinician through authentic discovery.

African-Americans historically have underutilized mental health services (Morris 2001). African-Americans attend fewer mental health sessions than Whites and in general terminate prematurely. Especially low are the statistics for continuation of talk therapy (Lasser 2002), with Blacks showing "…a preference for emergency services over ongoing treatment services, tertiary prevention over secondary prevention, and crisis mode over preventive mode" (Morris 2001, p. 563). Morris (2001) pointed to cultural factors including training deficiencies among therapists, stigma, and culturally inappropriate services, alongside barriers like transportation, inflexible schedules, lack of knowledge about resources, as well as economic constraints. Confirming the bidirectionality of distrust of clinical treatment among African-Americans, Morris (2001) found that among doctoral-level clinicians, less than half felt competent with African-American clients despite their training and exposure to diverse client populations. Richardson (2001) as cited by Winbush (2009) found that African-American parents of child clients reported significantly more negative expectations than did White parents. Their expectations were that providers would be untrustworthy, disrespectful, and would offer poor care. This demonstrable elevation of race over individuality in clinical social work practice points to the urgent need for a relational approach, wherein empathy and responsiveness to each client's reality is necessary and inclusive of the reality of distrust. The relationally oriented clinical social worker follows the principles of attunement, not-knowing, co-construction of meanings, and mutuality in treatment planning during the first visit to acknowledge client fears about what to expect this time around, and helps build trust and confidence in the newly forming relationship.

Case Illustrations of Relational Practice with African-American Clients

The relational approach to social work practice focuses on using the relationship between the client and the therapist as the "principal vehicle to affect change in the client…" (Tosone 2004, p. 481). This change can encompass all levels of interaction, including intrapsychic, interpersonal, and larger community systems. Tosone (2004) describes that this is done by the clinician making a clear effort to understand the internalized meanings that a client has assigned to the relevant interactions and the mutual influences that client and clinician can have on one another. This can include how interactions are being affected by larger systems in the client's environment. It also can include the impact of the social work practice environment, including social work agency systems as well as the clinician's own internalized configuration of self and of the client as representative of their respective cultural/racial groups.

The following case vignettes demonstrate the value of using a relational approach wherein cultural and racial factors may be different or similar between the client and the clinical social work practitioner. They illustrate the development of the clinical relationship and clarify that all clinicians, regardless of race, can experience significant benefit from the use of a relational approach with Black clients.

Case Illustrations Involving White Clinician and Black Client

A male African-American teenager was being seen by a female White clinical social worker for behavior issues that led to his recent suspension from school. The teenager had already developed a strong alliance with the clinician. He proceeded without hesitation to share his perceptions about the current situation, including his feelings of how Black students in his school were treated differently from White students. He clearly believed that if he had been White, he would not have been suspended.

The focus of the clinical interaction using a relational stance required a shift from the teenager as "client-in-situation" to one of the "client-and-clinician-in-situation." As a therapeutic dyad, the client and the social work practitioner were "recognized as being influenced by complex internal and external forces" (Tosone 2004, p. 483). The focus was on how the clinician would use the dynamics of the therapeutic relationship in service of the client developing a fuller appreciation for his own strengths and capacities and for recognizing how to best make use of the existing supports in his environment. The teen's perceptions and anger regarding differential treatment by school personnel, as well as the clinician's own unresolved feelings about racism and White privilege, could have triggered within the clinician a sense of guilt and/or over-responsibility. Unless the clinician was able to self-reflect and to acknowledge her reactions, the creation of a mutual relationship based on authentic interactions might quickly have been compromised or derailed. In this

case, mutuality did not mean that the therapist and the teenager were equals or that the therapist did not have more power than the teenager (Tosone 2004, p. 483). It did mean that the therapist could allow herself to be vulnerable in the presence of the client and to search together for reasonable explanations of what had transpired and what was needed to effectively empower and support the adolescent toward resolution of the issue.

The relational stance in which both are members of a relational dyad is compatible with the collective orientation to which many African-Americans subscribe (Boyd-Franklin 2003). This orientation is in contrast to a more individualistic orientation that characterizes traditional psychodynamic psychotherapy where the clinician is under no obligation and is in fact discouraged from revealing his reaction to the content being discussed by the client. In contrast, the relational social worker cannot relate authentically if attempting to hide her reactions when engaged with a client. In other words if this clinician truly believed that Black and White students were treated equally by the school administration, then it would be important for her to share her doubts and ask how the client had not only different perceptions but experience which supported his different perceptions. This example of clinician and client in context acknowledges that each person's transference and countertransference has roots in direct experience. Practicing from a relational theory base requires the clinician to express genuine curiosity and desire to understand the situation from the client's perspective and to invite the client to assist her in this task. The relational clinician's willingness to acknowledge not-knowing in a respectful way that requests the client's support in teaching understanding of the client's perspective, moves mutuality and co-construction forward. It also reduces risk due to revelation of holding differing perceptions of the same situation.

Another key reason for the compatibility of this approach with the collective orientation held by many African-Americans is its emphasis on the clinician's capacity to demonstrate genuine empathy. The demonstration of empathy suggests to the person in distress that he is not alone and has the companionship and support of someone who is truly interested in his overall well-being. While this is an attribute of a clinician which is important for most clients, its role in the treatment of this Black teenager offered direct contrast to daily instances of brief indignities, racial slights, and insults, intentional or not (Sue et al. 2007). To support her client in his distress, the relational clinician had to be grounded in a clear sense of her own identity, including flaws and vulnerabilities that sometimes may mirror those of the client and her defenses against acknowledging equivalent flaws and vulnerabilities. As described by Tatum (1997), "…in order to empathize one must have a well-differentiated sense of self in addition to an appreciation of and sensitivity to the differences as well as the sameness of another person" (p. 92).

The outcome for this case was one in which the client joined with the clinician in sorting out what had occurred in terms of his suspension. While there was blame on the part of the client related to his acting out behaviors, there was also clear evidence that the disciplinary action taken was more extreme than what had been used with other students. Consequently the clinician and the parent were in a position to advocate for the student to receive a more equitable consequence for his inappropriate

behavior. A relational social worker who is not school-affiliated could include in her role consultation with the mother regarding watchfulness of the school's responsiveness to her son as one of very few African-Americans students enrolled. This kind of intervention is in support of the creation of a stronger bond between mother and son particularly in light of the father's absence from the home.

An additional case illustration involved a young White male clinician working in a clinical social service clinic, assigned to work with a college-educated, unemployed Black mother and her teenage daughter. The mother was seeking therapeutic support for her daughter due to her daughter's failing grades and frequent displays of disrespectful behavior in their home. The therapist prided himself on being able to form strong working relationships with Black adolescent clients and for being able to determine which type of treatment might best benefit the teen, even if the treatment might be at odds with what the parent thought was needed.

The clinician consciously chose to meet with the adolescent alone and not to engage the mother's growing anxiety and displeasure with her daughter's treatment. While this decision was rationalized as assisting the teen with separation issues and encouraging a working relationship in which the client could find her own voice, the social worker did not reflect adequately on his countertransference overidentification with adolescents. He was therefore outraged when the mother went directly to the clinician's supervisor to report her dissatisfaction with the care that her daughter was receiving. He also was surprised by this mother's feeling of empowerment to express her opinions. That this mother did not fit the clinician's stereotype of the undereducated Black parent is an example of racial formation.

This scenario demonstrates how the absence of a relational stance can compromise the quality of the therapy provided. This clinician exhibited a lack of self-awareness regarding the potential impact of his presence as a White male authority figure on both mother and daughter. Since self-awareness is core to the success of a relational social work stance, the clinician would need to weigh the implications of the daughter being flattered by his attention and the mother feeling disrespected by his lack of willingness to hear her concerns about her daughter. The absence of self-awareness compromised this social worker's capacity to develop an authentic working alliance with the daughter and an empathetic and supportive relationship with the mother. A relational social work stance had little potential to be cultivated without there being significant adjustments on the clinician's part. There was an opportunity for the supervisor to intervene, redirecting and exploring the clinician's authoritarian and non-collaborative stance. This option was not pursued. As a result the mother terminated her daughter's therapy. Even more significantly, this experience of feeling disrespected may have left the mother more resistant to seeking out clinical services in the future for either herself or her daughter.

Another final case illustration involves a young White female social work clinician who was assigned to work with a middle-aged Black male client. From the beginning the clinician reported that she was keenly aware of the race and age differences between her and her client. She noted that as much as she felt that she and he had created a strong working alliance, she was keenly aware of questioning her own motivations particularly as they related to feeling guilt stemming from her

perception of her own White privilege. She knew how easy it was to align with a stereotypic image of her client as the Black man who was uninterested in self-reflection and perhaps dangerous, and the image of herself as a stereotypic White woman who was clinically trained and righteous. She engaged in a lot of reflection about these issues and used her supervisor as a support in this process in order that she might be prepared to respond to these issues as effectively as possible.

The clinician felt challenged because her client often talked of his anger toward Whites while at the same time suggesting that she was different from those Whites with whom he had had negative experiences. While his anger regarding racial discrimination was explicitly not being directed toward her, she wanted to have enough understanding of her own thoughts and feelings about racial differences so as to be able to stay empathic when his anger and hurt about these issues began to surface. By reflecting upon and monitoring her responses to the racial content of the client's life experiences and their implications, internal and interpersonal, in their treatment process, this relationally oriented clinician was able to stay present to the whole of their communications and to seek support and guidance as needed. Although not explicitly spelled out in relational theory, pursuing help to clarify perceptions and misperceptions further reflects the power of not-knowing and continuous self-reflection as a clinical contribution.

This authenticity in the clinician about her own contributions to the co-constructed relationship helped to support the building of a strong working alliance between her and this client. It would have been very destructive and disingenuous if she had bought into the idea that somehow issues of race were not relevant to their interactions. Even though the client wanted to protect her by suggesting that she was "different" from other Whites, it was important that she recognize and own her own participation as a White person in holding a position of privilege. While clearly she would not consciously choose to abuse a position of privilege with this or any client, the fact that she understood its potential impact was inevitably recognizable to the client without it even having to be spoken about directly. This is because the authenticity of a person can often be perceived based on the quality of the interaction and is not reliant on verification through verbal communication. All in all the clinician felt both challenged and pleased with the work she and her client were able to accomplish together.

Case Illustrations Involving Black Clinicians and Black Clients

A 15-year-old African-American female was court-referred for treatment at a public mental health clinic due to an incident of domestic violence against her mother. The client was assigned to work with an African-American clinician in her 50s whose socioeconomic status was middle class. The clinician had not had much previous experience working with adolescents or in a publicly funded treatment facility. During the session the clinician sought to engage the client's trust and attention to help her to better understand what treatment was needed. For her part

the client questioned how this treatment could help her: her cousin who had come to the same facility had not been helped. The clinician's response to the client was that she hoped things would be different for her and inquired no further. This non-relational response missed an opportunity to begin the creation of an authentic relationship. The relational social worker would want to learn more about what the client's expectations might be, to demonstrate empathy with the client about being forced to do something that she neither desired to do nor expected to be helpful. The goal in this initial session of creating interpersonal connection through mutuality was compromised.

This failure easily fits into Altman's (2007) description of the risk of attributing resistance to client dynamics rather than to the relational clinician's charge to accept resistance as expectable and valuable starting points for working with diverse, and particularly oppressed, client populations. By the second session, there was no mistaking the client's lack of interest when she flatly asked, "When is this session going to be over?" This is where the relational clinician might have used the client's impatience as an opening to value the client's time and to inquire what the client most wanted or needed from their interactions. This would have been a relational invitation to mutuality and co-construction of a purpose.

Understanding transference and countertransference dynamics are core elements of all clinical work and are active and transparent interactions for a relational social worker. Learning in retrospect is productive for all clinicians. In this case the relational social worker might recognize the strong negative transference reaction by the client at the very first session. That the clinician was similar in age and race to the client's mother could be one element which, for the clinician, engendered a positive countertransference reaction that could have obscured other aspects of the transference and countertransference. She had been responding to the client in ways similar to how she might have responded to her own daughter or how she would have wanted a clinician to respond to her own daughter. This misapprehension of the client's individual story as well as her own reactions to a "mother" countertransference probably intensified the client's negative transference.

This case demonstrates that racial matching of client and clinician does not insure a productive outcome. Without sufficient self-awareness, supported by the use of effective supervision, it is possible for the clinical social worker to miss the developmental as well as present environmental transference and countertransference dynamics or know how to use them relationally to advance clinical alignment. Matching of race as well as other significant dimensions of diversity such as sexual orientation, religion, socioeconomic class, and the like is sometimes requested by clients as necessary for them to engage in clinical work. It is incumbent upon the relational social worker to be vigilant, recalling that there is often more diversity within groups than between groups. The relational social worker must not be lulled into making assumptions about similarities between herself and her client that are ill founded and even more so obscure accurate assessment. Adopting a stance of not-knowing and engaging in a process of co-inquiry to support the creation of realistic goals in the client's real situation are required for effective use of a relational stance.

A second case illustration involved a young African-American woman who was in treatment with an African-American clinician who was slightly older. Both client and clinician had been raised in a religiously conservative households and held similar values. Over time the client and the social worker developed a strong connection that entailed a positive maternal transference/countertransference dynamic, manifestly if not entirely fueled by their similarities in race and religious values. It was well into the treatment that the client finally decided to share with the clinician the secret that she was gay. The clinician was blindsided by this revelation and immediately went silent. The "blind side" was in fact the clinician's overgeneralization of sameness based on her racial and religious assumptions. Her evident emotional retreat from the probably prematurely intimate sense of engagement aroused fear, anger, and tears in the client, and the clinician in response moved to abruptly end the session. This dramatic illustration of unexamined countertransference, including positive feelings of affinity, is a caution to all social workers about maintaining constant self-examination as a relational principle that applies regardless of apparent mutuality. The relational clinical process is always evolving, never complete and permissive of assumptions. The client was looking to the clinician for acknowledgement and supportive empathy about being gay as an aspect of her identity, which she might well have expected given their apparent congruence up to that point. The clinician was unable to provide either because she too had mistaken common features for common understandings and values.

What becomes clear is that clinician and client sharing the same race and background are in and of themselves neither necessary nor sufficient conditions for creating a mutual, authentic relationship. The importance of self-reflection and examination on the part of the clinician cannot be overestimated when the goal is to work from a relational stance. In this particular case after the passage of several months, the relational social worker and client were able to meet again, and the clinician used the relational skills of inquiry and not-knowing to check what had previously been a mistaken attunement: she was able to be authentic in her acknowledgement of misunderstanding, engage in a process of repair and rebuilding of a trusting relationship with the client, and re-engage in actual empathic attunement. Thereafter, all the relational skills, including co-construction and mutuality in building the basis of the treatment contract, were able to be brought into using the "collision" (Bromberg 2011) to introduce issues of sexuality and of sexual orientation that had been hidden in the client's life as well as between her and this client. As the clinician became curious about her own discomfort with inquiring about issues of sexuality and sexual orientation, when appropriate, which was obviously missing with this client in particular and with all of her other clients in general, she came to understand the value of cultural competence as ever expanding. She now had a clear example of the difference between having the intention of being culturally competent and the actual practice of it. She also had a clearer understanding of how an inaccurate or incomplete assessment can lead to a rupture or impasse and potentially to premature termination.

Conclusion

As stated at the beginning of this chapter, relational social work practice with African-Americans presents both challenge and promise. Based on the information and cases reviewed in this chapter, the use of a relational approach (in this case with African-American clients) works for the benefit of both the client and the clinician, but in different ways. For the client there is the opportunity to build an authentic relationship that becomes a safe place to examine and to work out important and often painful emotional concerns. Some of these concerns may evolve from experiences directly related to race and yet may be linked to deeply held individual meanings and internalized relational paradigms related to the client's immediate needs. For some clients this may be the first time where they have been willing to look at their concerns, even though they may have been long standing and the source of significant pain and mental anguish.

For the social work clinician, it is inevitable that her own flaws, conflicts, and vulnerabilities at some point will be triggered in the effort to stay authentically engaged with the client. Attachment and separation are rigorous processes in development; turbulence of the same nature occurs in clinical practice as well. The relational perspective recognizes not only the centrality but also the activity involved in engagement, assessment, co-construction of a meaningful treatment plan, and maintenance of connection through the often turbulent process of personal growth that successful clinical social work practice requires. It is the clinician's ethical responsibility to work through her own unresolved issues so as not to impinge on the work being done with the client. It is the social worker's relational expertise that allows her to accomplish this work as an ever-present aspect of the treatment process. African-American clients, with well-documented skepticism about psychodynamic treatment, intensify these processes when the clinician is not African-American. At the same time, all clinicians benefit from opportunities to be keenly aware of the value of mutuality and co-construction throughout the clinical social work process. In the final analysis, improved treatment outcomes for African-American clients, and a clear sense of professional competence and satisfaction with one's professional work for the clinician, are all worthy accomplishments that honor the investment of time and energy that the relational theory approach requires.

Study Questions

1. What is the significance of the quote "…few issues are as 'value laden and misunderstood as is race' " (Hardy 1994, p. 5)?
2. What key understandings about the social, political, biological, and historical contexts of African-Americans in the United States would be helpful to keep in mind in working with Black clients?
3. Define the term "racial formation" and describe its implications for social work practice with client populations other than African-Americans.

4. Discuss factors that have contributed to the general underutilization of mental health services by African-Americans and how these are instructive about relational contributions to work with oppressed populations.
5. Describe how potential countertransference traps related to race could potentially undermine the treatment process.
6. Describe, using one of the cases above, how the social worker used relational principles. Give a specific example and name the relational principle.

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